FRAMEWORK FOR STATE EVALUATION
OF CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: Wisconsin
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

(Signature of Agency Head)

Date: March 31, 2000

Reporting Period: FFY 99. BadgerCare not implemented in FFY 98.

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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

The estimated baseline of uninsured low-income children below 200 percent Federal Poverty Level (FPL) is 54,000. The estimated baseline of uninsured low-income children can be further broken down into categories that correspond to the two phases of BadgerCare implementation described below:

- The estimated baseline of uninsured low-income children below 100 percent FPL is 23,000.

- The estimated baseline of uninsured low-income children from 100 percent FPL to 200 percent FPL is 31,000.

BadgerCare was implemented in two phases. Phase 1 was the acceleration of OBRA children under 100 percent FPL born before October 1, 1983. Phase 1 was implemented April 1, 1999.

Phase 2 of BadgerCare was coverage of children under 19 and their custodial parents (and their spouses) with income not exceeding 185 percent FPL. Once eligible, families remain in BadgerCare as long as their income does not exceed 200 percent FPL. Phase 2 was implemented July 1, 1999.

Since Wisconsin implemented both phases of BadgerCare in 1999, the State did not submit an annual report in 1998. Therefore, the baseline estimates described above are the only baseline estimates we have submitted to HCFA for the annual CHIP reports.

We did submit different baseline estimates in the two BadgerCare CHIP State Plan Amendments we have submitted to HCFA, but those estimates were based on the 1995 Wisconsin Family Health Survey data. The above baseline estimates are based on the combined 1997/1998 Wisconsin Family Health Survey data, which have recently become available. For more information on the Wisconsin Family Health Survey, see Section 1.1.1 below.

1.1.1 What are the data source(s) and methodology used to make this estimate?

The Wisconsin Family Health Survey (FHS) is the data source for the baseline estimate. The FHS is a statewide disproportionate stratified random-sample telephone survey of Wisconsin households, conducted year-round. The survey collects information about health status, use of health care services, and health insurance coverage. The FHS is managed by the Bureau of Health Information, Division of Health Care Financing and conducted by the Wisconsin Survey Research Laboratory, University of Wisconsin-Extension.

The individual in each survey household who is most knowledgeable about the health of all household members answers all survey questions, providing information about everyone living in the household. The population estimates are constructed from each sampled individual by weighting to adjust for different sampling rates by stratum, weighting to adjust for varying response rates by stratum, and post-stratification into the age-sex distribution of the Wisconsin household population as estimated from census data. Population estimates are rounded to the nearest thousand. The FHS sampling frame consists of all Wisconsin households with a working telephone.

The FHS sample design for selecting telephone numbers for the survey divides the state into six sample strata, five of which are defined geographically by grouping all Wisconsin counties into five areas. Telephone area code/prefix combinations from these five strata were randomly sampled at rates proportionate to the population size of each stratum. A sixth stratum, consisting of telephone prefixes within the City of Milwaukee that had previously been found to include at least 20 percent African-American respondents and was also randomly sampled.

The baseline is derived from a sample comprised of the 1997 and 1998 Family Health Survey. In 1997 the FHS collected information for 7,150 individuals living in 2,638 households. In 1998, the survey collected information for 6,560 individuals living in 2,463 households. Over the two years combined, there were 1,145 uninsured persons in the combined 1997-1998 sample.

The estimated baseline measures the uninsured at a point in time.

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The State has utilized the most current survey sample available to produce the estimated baseline. The FHS was began 1989, and is conducted on a continuous basis, collecting information every month. The survey is conducted by trained interviewers who speak with the household member most knowledgeable about the health and insurance coverage of all household members.

The survey results are representative of Wisconsin household residents, who constitute approximately 97 percent of all persons residing in the state. Non-household residents, including persons living in nursing homes, dormitories, prisons, and other institutions constitute the remaining 3 percent who are not represented in the survey.

The Confidence Interval for the estimated baseline is (+/-) 9,000.

The baseline estimate represents estimated number of uninsured low-income children based on survey responses. The estimate should not be treated as a precise result as it is derived from a sample.

The Wisconsin Family Health Survey uses a larger random sample for Wisconsin than does equivalent uninsured data from the Census Bureau. In addition, the FHS specifically asks questions about being uninsured, unlike the Census Bureau. The Census Bureau arrives at its estimate through the residual method, which simply assumes that anyone who did not report having health insurance is actually uninsured. The lack of a direct question about being uninsured is a serious omission, which can result in an overestimate of the proportion uninsured.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A)).

BadgerCare enrollment as of September 30, 1999, just three months after full implementation, included 6,298 children who were previously uninsured, and 4,130 low-income teenagers (OBRA). The total number of children with creditable health coverage under BadgerCare was 10,428 - approximately 19 percent of the estimated baseline of uninsured low-income children. (See Tables of BadgerCare enrollment in Section 1.3 and Section 3.6.2 for more information on BadgerCare enrollment.)

Progress in increasing number of children with creditable health coverage since FFY 99

BadgerCare enrollment as of February 2000 is 19,294 children. In addition, 8,253 children have enrolled in Medicaid as a result of the BadgerCare outreach and coordination with the Medicaid program. Thus, a total of 27,547 children have enrolled in BadgerCare/Medicaid since the implementation of BadgerCare, which represents 51 percent of the baseline estimate of uninsured children below 200 percent FPL.

1.2.1 What are the data source(s) and methodology used to make this estimate?

Wisconsin Medicaid eligibility files are the data source for enrollment data. The estimated baseline is described above.

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Please refer to the response in Section 1.1.2.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

TABLE 1.3		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
BadgerCare will increase the number of insured children and adults in Wisconsin.	Expect to see the full budgeted BadgerCare enrollment (as reflected in the Wisconsin Section 1115 Waiver) during Calendar Year 2000 - 48,800 recipients: 22,700 children, or 42% of baseline estimate of 54,000 uninsured low income children; 26,100 adults, or 29% of baseline estimate of 90,000 uninsured low income adults.	Data sources: Estimates of uninsured children and adults under 200% FPL in Wisconsin are taken from the combined 1997 and 1998 sample of the Wisconsin Family Health Survey. Recipients enrolled in BadgerCare taken from the MMIS (HMKR481Q report). Methodology: Measure progress in reducing the number of uninsured children and adults in Wisconsin by comparing BadgerCare enrollment to the universe of the uninsured low-income children/ adults. Numerator: Through September 1999 BadgerCare had enrolled 10,428 children and 16,853 parents. An additional 2,473 Healthy Start children were enrolled in Medicaid due to BadgerCare outreach and Medicaid/BadgerCare coordination. Denominator: Based on the Wisconsin Family Health Survey there are 54,000 uninsured children under 200% FPL; there are 90,000 uninsured adults under 200% FPL. Progress Summary: In the first 3 months of BadgerCare (July – September 1999) the program has enrolled 24.1% of the uninsured low-income children in Wisconsin. The program has also enrolled 18.7% of the uninsured low-income adults in Wisconsin.

Additional Narrative for Program Experience Since September 1999

Overall Coverage of Children in Medicaid and BadgerCare through February 2000

Current Wisconsin Medicaid and BadgerCare covers children in the following family-related categories:

Category of Children		FPL
Medicaid:	AFDC- Related up to Medically Needy Level	68% FPL
Medicaid:	Healthy Start Children Under 6	185% FPL
Medicaid:	OBRA Children Born After 9/83	100% FPL
BadgerCare:	Children under 19	200% FPL

The following data through February 2000 shows the current count of children enrolled in Healthy Start and BadgerCare categories by age:

Healthy Start	Count	BadgerCare	Count
Age 0-5	44,551	Age 0-5	763
Age 6-16	30,525	Age 6-12	6,711
		Age 13-19	11,818
Total	75,076		19,294

There are an additional 90,334 children under age 19 covered under the Medicaid sub-programs that are tied to the AFDC and AFDC–related rules that still exist as Medicaid eligibility categories. We do not break down this category by age in routine reports.

There are also some children who are counted within the adult categories, because they are pregnant or already a parent. They are counted as heads of household for federal reporting purposes and therefore reflected in these counts as adults, but they are children by age – under age 19. There are about 1,800 teenagers in this category in BadgerCare and another 8,000 in Healthy Start.

BadgerCare's coverage of parents of children was established in the context of Wisconsin's comprehensive Medicaid coverage of non-disabled adults under 65 and very high rate of insured residents.

Wisconsin Medicaid covers non-disabled custodial parents in AFDC-related families at an average income standard of 55 percent of the FPL. This custodial parent income standard compares favorably with the national median income standard of 45 percent FPL for AFDC-related custodial parents. In addition, pregnant women are covered up to 185 percent FPL.

Ninety-six percent of Wisconsin's residents had health insurance. This is the highest rate in the United States.

Given this background, BadgerCare's coverage of parents was specifically targeted to the truly needy - those uninsured parents losing Medicaid as a result of increased income due to welfare reform; and, those parents not previously involved in public assistance who do not have access to affordable health insurance.

BadgerCare's coverage of parents is funded with Title XIX funds, not Title XXI funds.

BadgerCare Experience Through February 2000

We have BadgerCare program data through February 2000 at the time this report is being prepared.

Through February 2000, the program has enrolled 19,294 or 35.7 percent of the uninsured low-income children in Wisconsin. In addition, due to successful outreach and the coordination between Medicaid and BadgerCare, we have also enrolled an additional 8,253 in Medicaid - 15.8 percent of the uninsured low-income children in Wisconsin. The combined impact of BadgerCare/Medicaid has enrolled 27,547 or 51 percent of the uninsured low-income children in Wisconsin.

BadgerCare has exceeded the performance measure for children for this strategic objective in the first 8 months of implementation

Through February 2000, the program has enrolled 38,188 or 42.4 percent of the uninsured low-income adults in Wisconsin.

BadgerCare has exceeded the performance measure for adults for this strategic objective in the first 8 months of implementation.

By June 2001, BadgerCare enrollment is projected to be 81,990, compared to 67,535 now budgeted. Higher BadgerCare enrollment will increase the number of children from the current 19,294 to 25,757 by June 2001. We also project new Medicaid Healthy Start children will double, increasing from 8,253 to 16,000.

This will bring the total number of uninsured low-income children enrolled due to the combined impact of BadgerCare/Medicaid to 41,757, or 77.3 percent of the total uninsured low-income children in Wisconsin.

By June 2001, BadgerCare enrollment of adults is projected to be 56,233. This represents 62.5 percent of the total uninsured low-income parents in Wisconsin.

Please see the table below for the FFY 99 experience in increasing the number of insured children and parents.

BadgerCare Enrollment/BadgerCare Eligible Remaining Uninsured
As of September 30, 1999

	Adults	Children	Total
Uninsured Under 200% of FPL (Based on 1997 & 1998 FHS Sample)*	90,000	54,000	144,000
Enrolled in BadgerCare	16,853	6,298	23,151
Low Income Teenagers (OBRA Expansion)		4,130	4,130
Total BadgerCare	16,853	10,428	27,281
Increased Medicaid Healthy Start Children due to BadgerCare Outreach and BadgerCare/ Medicaid Coordination		2,563	2,563
Total BadgerCare and Medicaid Increase	16,853	12,991	29,844
As percentage of uninsured under 200% FPL 200% FPL	18.7%	24.1%	20.7%
Estimated BadgerCare Eligible Remaining Uninsured	73,147	41,009	114,156
As percentage of uninsured under 200% FPL	81.3%	75.9%	79.3%
BADGERCARE ENROLLMENT THROUGH FEBRUARY 2000			
Enrolled in BadgerCare	38,188	15,108	53,296
Low Income Teenagers (OBRA Expansion)		4,186	4,186
Total BadgerCare	38,188	19,294	57,482
Increased Medicaid Healthy Start Children due to BadgerCare Outreach and BadgerCare/ Medicaid Coordination		8,253	8,253
Total BadgerCare and Medicaid Increase	38,188	27,547	65,735
As percentage of uninsured under 200% FPL	42.4%	51%	45.6%

* Based on the most recent Family Health Survey data for the years 1997 and 1998, it is estimated that there were 54,000 uninsured children living in households with income below 200 percent of the FPL.

TABLE 1.3		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
Improve outreach and increase enrollment of Medicaid eligible children and parents	Improve the rate at which persons entitled to Medicaid apply for and enroll in Medicaid through integrated Medicaid/ BadgerCare outreach and coordination between BadgerCare and Medicaid. Growth rates in Medicaid TANF/ Healthy Start have been either negative or nominally positive in recent years.	Data sources: MMIS Monthly Eligibility Report (481Q) Methodology: Compared the growth in Healthy Start Medicaid eligibles in the 3 months of BadgerCare implementation (July – September 1999) compared to the growth in Healthy Start Medicaid eligibles in the 6 months prior to July 1999. Differences in growth in the two periods are primarily due to Medicaid/BadgerCare outreach and the impact of BadgerCare enrollment and coordination with Medicaid. Numerator: June, 1999 HS Medicaid Children - 73,427 Sept, 1999 HS Medicaid Children - 75,990 Denominator: January 1999 HS Medicaid Children – 72,719 Progress Summary: In the 6 months prior to BadgerCare, Healthy Start Children increased by 708, or an average monthly growth rate of .3%. In the 3 months of BadgerCare implementation, Healthy Start Children increased by 2,563, or an average monthly growth rate of 1.2%.

Additional Narrative for Program Experience Since September 1999

In the first eight months of BadgerCare implementation, from July 1999 through February 2000, Healthy Start Children increased by 8,253, or an average monthly growth rate of 1.4 percent. By February 2000, Healthy Start enrollment was up to 82,970.

We are currently projecting that Healthy Start Children growth due to BadgerCare outreach and BadgerCare/Medicaid coordination will increase to 16,000 by June 2001, the end of the current state budget biennium.

The overall level of family Medicaid caseload has stabilized by January 1998 after declining in 1996 and 1997.

The number of family Medicaid recipients decreased from 296,000 in December 1995 to 220,000 in December 1997. This period coincides with the phasing out of AFDC and the implementation of Wisconsin Works (W-2). The family Medicaid caseload stabilized in late 1997 and in 1998. From January 1998 to June 1999, the number of recipients ranged between 215,000 and 221,000.

The stabilization was the result of a concerted statewide outreach effort.

The combined Medicaid/BadgerCare caseload has increased significantly since mid-1999. The combined family Medicaid/BadgerCare caseload increased from 222,000 recipients in July 1999 to 275,424 in February 2000.

Statewide outreach efforts for both Medicaid and BadgerCare, including training, TV ads, and agency collaboration contributed to this growth.

TABLE 1.3

Strategic Objective	Performance Goals	Performance Measures and Progress
OTHER OBJECTIVES - PREVENTION OF CROWD-OUT		
Crowd-out will not occur	Automated edits and procedures in the CARES eligibility determination system and the MMIS will prevent BadgerCare enrollment of families with: • current coverage • coverage in the 3 months prior to application, • current access to ESI subsidized by the employer at 80% or more of premium costs • access in the 18 months prior to application	Data sources: CARES eligibility determination application denial edits; MMIS HIPP eligibility determination denial edits. Methodology: Report aggregate statistics on number of BadgerCare applicants denied eligibility due to current/3 month retroactive insurance coverage; current/18 month retroactive access; HIPP applicants denied eligibility due to 6 month retroactive coverage by 60%-80% subsidized coverage. Numerator: Coverage denials; Access denials; HIPP retroactive coverage denials. Denominator: Total applicants for BadgerCare Progress Summary: The automated edits described above are operational. Detailed statistics on the edit "hits" are not available at this time. However, other evidence supports the fact that Wisconsin is meeting this performance goal. As of February, 2000, over 90% of recipients enrolled in BadgerCare are below 150% FPL. These families are the most likely income group to be uninsured. Based on the survey of employers that Wisconsin does to verify BadgerCare enrollees current

TABLE 1.3		
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	or HIPP enrollment if covered by ESI subsidized by the employer between 60% and 80% of monthly	insurance status, 64% of employers surveyed indicate that the employee has no access to family coverage.

Additional Narrative on Potential Barriers to Preventing Crowd-out/Future Plans for Monitoring

Barriers to meeting goals of preventing crowd-out in BadgerCare:

- Current federal policy on CHIP programs buy-in of employer-sponsored insurance (ESI) prevents states from buy-in if the recipient's employer pays less than 60 percent of the family premium. This lower limit to ESI subsidy rates artificially lowers the target population of BadgerCare recipients who could be bought in to ESI in a cost-effective manner. We have more comment on this current federal CHIP policy in Section 5.3 of this report.

Future plans for preventing/monitoring of BadgerCare crowd-out:

- Implement Wisconsin Family Health Survey refinements relating to employment status, income and access to health insurance.
- Continue education and outreach for eligibility workers, employers with low income employees.
- Survey employers based on national models (Institute for Health Policy Solutions/ RAND).
- Survey enrollees to provide more detailed information regarding decision-making and participation with regard to employer-sponsored insurance.

TABLE 1.3		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
BadgerCare enrollees will report satisfaction with access to care in terms of waiting time for appointments, ability to get referrals, etc.	BadgerCare HMO enrollees will report the same level of satisfaction with access to care, based on standard indices, as TANF/ Healthy Start Medicaid HMO enrollees	Data sources: CAHPS Survey performed by 3rd party contractor. Methodology: In Calendar Year 2000, the CAHPS Survey for Medicaid HMOs will sample both AFDC-Related/Healthy Start Medicaid HMO enrollees and BadgerCare HMO Enrollees, and report on enrollee satisfaction for the 2 samples. Numerator: Composite indices for enrollee satisfaction with access for separate AFDC-Related/Healthy Start Medicaid HMO enrollee and BadgerCare HMO Enrollee samples. Denominator: Not relevant Progress Summary: CY 2000 CAHPS survey has not been implemented yet. Since BadgerCare started in 7/99, there was insufficient enrollment data and time for BadgerCare enrollees to be included in the CY 1999 CAHPS survey.
OTHER OBJECTIVES - POSITIVE IMPACT ON DELIVERY SYSTEMS		
BadgerCare will result in greater Medicaid HMO capacity in Wisconsin	The BadgerCare program will increase the number of enrollees in Medicaid HMOs in contrast to previous declining growth in enrollment.	Data sources: MMIS HMO enrollment data Methodology: Compare Medicaid HMO enrollment prior to BadgerCare implementation to Medicaid HMO enrollment at the end of FFY 99. Numerator: Medicaid HMO enrollment as of 9/99. Denominator: Medicaid HMO enrollment as of 6/99 Progress Summary: Medicaid HMO enrollment for TANF/Healthy Start women and children as of 6/99 was 182,669. Medicaid HMO enrollment for AFDC-Related /Healthy Start women and children/BadgerCare as of 9/99 was 186,024. This represents an increase in Medicaid HMO enrollment of 1%.

TABLE 1.3		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
		Since BadgerCare was only implemented in July 1999, it was too soon to see a real impact on Medicaid HMO enrollment by September 1999 due to the 6 - 10 weeks it takes for the HMO enrollment choice process to be completed.
		Additional Narrative to reflect progress through March 2000 By March 2000, Medicaid HMO enrollment had grown to 220,410, an increase of 20.7% since BadgerCare implementation. This increased HMO enrollment is a result of an increase in both AFDC-Related/Healthy Start children and BadgerCare HMO enrollment.

The following strategic objectives relate to increasing access to care, use of preventive care, and other objectives relating to quality of care.

These strategic objectives, and their performance goals and measures, differ somewhat from the objects/goals/measures that were previously described in the CHIP State Plan Amendment (SPA).

The SPA strategic objectives used a limited set of measures from our annual HMO Utilization/ Survey Report, HMO Targeted Performance Improvement Measures (TPIM), and the overall Quality Assurance and Performance Improvement (QAPI) initiatives. However, since we are requiring HMOs to report a separate annual Utilization/Survey Report for BadgerCare enrollees, to apply QAPI to their BadgerCare enrollees, and since the TPIMs apply to all HMO enrollees, we have decided to use the full set of measures for BadgerCare.

The SPA performance goals compared BadgerCare HMO enrollee experience with Medicaid fee-for-service (FFS) experience. Since the SPA was submitted, however, Wisconsin has discontinued comparing Medicaid HMO enrollee experience to Medicaid FFS experience. This is because the Medicaid HMO program is now a statewide program and there are limited comparable FFS populations to use as a basis of comparison. Therefore, we plan to define the performance goals for BadgerCare HMO enrollees in the areas of access, use of preventive care, and other quality measures as being met if their experience is equivalent to the experience of the TANF/Healthy Start pregnant women/child HMO enrollee experience.

With regard to the TPIMs, BadgerCare and TANF/Healthy Start HMO enrollees are combined. The performance goals are standards based on national/state goals.

TABLE 1.3

QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
OTHER OBJECTIVES:	***Quality of Care –Preventive and Chronic Disease State Care Performance Measures Targeted Performance Improvement Measures***	
Childhood immunizations	90% of enrolled children will be fully immunized by age 2 years.	Data sources: Encounter data, medical record review. Methodology: Utilization measure. Numerator: 3 Hep. B, 4 DTaP/DTP/DT, 2 Hib, 3 IPV (or OPV for 1999 services only--IPV only for services in 2000), and 1 MMR, each reported as individual numerators, contraindicated items can automatically be excluded. Combination rate including the following: 3 Hep. B, 4 DTaP, 2 Hib, 3 IPV/OPV, 1 MMR. Child must have different dates of service in the reporting year. At least one of the Hepatitis B vaccinations must fall on or between the child's sixth month and second birthday. Denominator: All children enrolled on their second birthday, with the second birthday falling in the reporting year and at least ten months of continuous enrollment with not more than one break in enrollment of 45 days prior to the child's second birthday and who received the required immunizations. Progress Summary: Measure specifications completed. This is a modification from the previous measure, updating the numerators to reflect current CDC-ACIP recommendations and with revised enrollment criteria in the denominator. Data for Calendar Year 2000 will not be available until August, 2001.

QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Lead Toxicity	2000: 65% of all eligible enrollees to have had lead toxicity screenings. The objective for calendar year 2001 is 85%. Two rates must be reported, one for one year olds and one for two year olds.	Data sources: Encounter data, medical records, public health screening data. Methodology: Service utilization measure. Numerator: The number of children in the denominator who had a blood lead screening performed by age one and age two years. Criteria: a) encounter with CPT-4 code 83655 or, b) medical record review data indicating blood lead test. Denominator: **L-1 Denominator for lead screening (For children from 6 to 16 months of age, inclusive)**: Any child that turned 16 months of age (inclusive to the last day of the sixteenth month) during the reporting year and was enrolled in the HMO at their first birthday and had ten months continuous enrollment with no more than one break in enrollment of up to 45 days prior to reaching 16 months of age. **L-2 Denominator (For children from 17 to 28 months of age, inclusive)**: The number of children 17 to 28 months (inclusive) of age who had their second birthday during the reporting year and were enrolled in the HMO at their second birthday with ten months continuous enrollment with no more than one break in enrollment of up to 45 days prior to reaching 28 months of age. The age cohort for this measure begins with the first day of the seventeenth month of life and includes the time period up to the last day of the 28th month of life. Progress Summary: Revised age cohort specifications implemented for 2000-01 HMO contract. Data for Calendar Year 2000 will not be available until August, 2001.

QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Preventive dental care.	For calendar years 2000 and 2001 enrollees will receive preventive dental services at a rate greater than or equal to 110% of the preventive dental services rate for FFS recipients. Comparative preventive dental service rates are reported in the Wisconsin Medicaid Comparison Report: 1996.	Data Sources: Encounter data or medical records. Methodology: Utilization measure. Numerator: The number of enrollees age 3 to 21 and age 21 and over who have had at least one preventive dental service during the reporting year, separated by county of residence of the enrollee. A member is identified as having a dental visit if he or she has had a claim/encounter that includes both a clinical oral evaluation and prophylaxis as defined by the following CDT-2 Current Dental Terminology (CDT) codes. Denominator: The number of children age 3 to 21 and age 21 and over enrolled in the HMO during the reporting year. Progress Summary: Baseline year for performance standard revised for implementation in 2000-2001 HMO contract. Data for Calendar Year 2000 will not be available until August 2001.
Follow-up care after inpatient mental health care.	Improve rate of follow-up care by 7 and 30 days post discharge by 10% over baseline year (2000) in 2001. This improvement goal is based on a 10% improvement in adverse outcomes.	Data sources: Encounter data, medical record review. Methodology: Utilization measure. Numerator: The number of discharges in the denominator that were followed by an ambulatory mental health encounter or day/night treatment within 7 and 30 days of hospital discharge. Ambulatory follow-up encounters are identified by the CPT-4 codes or UB-92 revenue codes specified. Denominator: Discharges for enrollees age six years and older at the time of discharge who have been hospitalized with a discharge date occurring during the first 335 days of the reporting year and a principal ICD-9-CM diagnosis code indicating a mental health disorder specified below, and who were continuously enrolled without breaks for 30 days after discharge.

QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
		Progress Summary Data for Baseline Calendar Year 2000 will not be available until August, 2001.
Follow-up care after inpatient treatment for substance abuse.	To increase the rate of ambulatory follow-up treatment within 7 and 30 days of discharge for individuals with specific substance abuse disorders, by 10 percentage points each year. This improvement goal is based on a 10% improvement in adverse outcomes	Data sources: Encounter data, medical record review. Methodology: Utilization measure. Numerator: The number of discharges in the denominator that were followed by an ambulatory substance abuse encounter within 7 and 30 days of discharge. Denominator: Discharges for enrolles age six years and older at the time of discharge who have been hospitalized with a discharge date occurring during the first 335 days of the reporting year and a principal ICD-9-CM diagnosis code indicating substance abuse, and who were continuously enrolled without breaks for 30 days after discharge. Progress Summary Data for baseline Calendar Year 2000 will not be available until August, 2001.

QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Outpatient Management of Diabetes	To measure and improve performance of outpatient management services for people with Type 1 or Type 2 diabetes. The goal for 2000 is establishment of baseline data for the provision of the following services to enrollees with diabetes: 1. Hemoglobin A1c (HbA1c) testing, CPT-4 code 83036; and, 2. Lipid profile testing, CPT-4 code 80061, 83720 or 83721.	Data sources: Encounter data, medical record review. Methodology: Utilization measure. Numerators: **Hemoglobin A1c:** HbA1c tests conducted in the reporting year. Administrative data or medical record review may be used to identify services. CPT-4 code 83036 or medical record lab report including result for service provided in the reporting year. **Lipid profile:** LDL test done during the reporting year or year prior to the reporting year. Administrative data or medical record review may be used to identify services. CPT-4 code 80061, 83720 or 83721 or medical record lab report including result. Denominator: Enrollees age 18-75 years as of December 31 of the reporting year. Must be continuously enrolled for ten months with no more than one gap in enrollment of 45 days in the reporting year. Those who were dispensed insulin and/or oral hypoglycemics/antihyperglycemics during the reporting year on an ambulatory basis, or had at least two encounters with different dates of service in an ambulatory setting or nonacute inpatient setting or one encounter in an acute inpatient or emergency room setting during the reporting year with diagnosis of diabetes. Progress Summary Data for baseline Calendar Year 2000 will not be available until August, 2001.

QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
OTHER OBJECTIVES: ACCESS TO CARE/USE OF PREVENTIVE CARE/ QUALITY OF CARE ***Access to services and other utilization measures*** ***Clinical and non-clinical priority areas.***		
Clinical priority areas	Performance goals may be set by the HMO.	Clinical priority areas are those identified by the state in the contract that the HMO may choose to measure and implement performance improvement projects in. Optional clinical topic areas include: 1. prenatal services; 2. identification of adequate treatment for high-risk pregnancies, including those involving substance abuse; 3. evaluating the need for specialty services; 4. availability of comprehensive, ongoing nutrition education, counseling, and assessments; 5. Family Health Improvement Initiative: Smoking Cessation; 6. children with special health care needs; 7. outpatient management of asthma; 8. the provision of family planning services, 9. early postpartum discharge of mothers and infants; 10. STD screening and treatment; and 11. high volume/high risk services selected by the HMO. <u>Progress Summary</u> Data for Calendar Year 2000 will not be available until October, 2001.
Non-clinical priority areas	Performance goals may be set by the HMO.	Non-clinical priority areas are those identified by the state in the contract that the HMO may choose to measure and implement performance improvement projects in. Optional non-clinical topic areas include: 1. Grievances, appeals and complaints; and 2. Access to and availability of services.

QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
		In addition, the HMO may be required to conduct performance improvement projects specific to the HMO and to participate in one annual statewide project that maybe specified by the Department. Progress Summary Data for Calendar Year 2000 won't be available until 9/2001.
OTHER OBJECTIVES: ACCESS TO CARE/USE OF PREVENTIVE CARE/ QUALITY OF CARE ***Enrollee satisfaction***		
CAHPS survey of BadgerCare HMO enrollee satisfaction.	Aggregation of baseline data on overall satisfaction. BadgerCare HMO enrollee satisfaction will be equivalent to TANF/Healthy Start HMO enrollee satisfaction	CAHPS survey data aggregation methodology to be implemented by third-party contractor. Progress Summary CAHPS data on BadgerCare HMO enrollees for CY 2000 will be reported on in late spring/early summer CY 2001

QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Satisfaction with referral for mental health/ substance abuse care subset.	Aggregation of baseline data on overall satisfaction with referral for MH/SA services. BadgerCare HMO enrollee satisfaction will be equivalent to TANF/Healthy Start HMO enrollee satisfaction	This performance improvement area establishes a baseline measure of enrollee satisfaction with referral for mental health and substance abuse services based on enrollee responses to the following specific questions. These questions will be included in the standardized Consumer Assessment of Health Plan (CAHPS) survey administered by the Department. This measure assesses the number of enrollees indicating they "need help with an alcohol, drug or mental health problem" as the denominator and the number of enrollees that indicate they did or did not actually get counseling or help as the numerator. The results will be aggregated by the Department or its contractor and reported to the respective HMO. The Department may specify minimum performance levels and require that HMOs develop action plans to respond to performance levels below the minimum performance levels. Progress Summary CAHPS data on BadgerCare HMO enrollees for CY 2000 will be reported on in late spring/early summer CY 2001
OTHER OBJECTIVES: ACCESS TO CARE/USE OF PREVENTIVE CARE/ QUALITY OF CARE ***Standardized utilization survey measures***		
Women's health measures: maternity care.	Trend and monitor utilization, LOS after delivery. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts	Tracks number of all deliveries with live birth and inpatient days by age cohort. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: All C-section and vaginal deliveries with live birth. Denominator: Not applicable. Not reported as a percentage

QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
		Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000)
Women's health measures: C-sections.	Trend and monitor utilization, LOS after delivery. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts	Tracks number of deliveries by Cesarean section with live birth and inpatient days by age cohort. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: All c-section deliveries with live birth. Denominator: All live births. Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000)
Women's health measures: VBAC.	Trend and monitor utilization, LOS after delivery. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks number of vaginal births after Cesarean section (VBAC) with live birth and inpatient days by age cohort. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Vaginal deliveries after previous c-section. Denominator: All live births. Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000)

QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Women's health measures: substance abuse treatment concurrent with pregnancy/ delivery	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks number of women who delivered live birth and had substance abuse services. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: All deliveries with live birth for enrollees receiving SA services in the 300 days prior to delivery. Denominator: Not applicable. Not reported as a percentage Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000)
Women's health measures: HIV testing at delivery.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts	Tracks number of women who delivered live birth and had HIV testing. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: All deliveries with live birth for enrollees receiving HIV testing in the 300 days prior to delivery. Denominator: Not applicable. Not reported as a percentage Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000)

QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Women's health measures: mammography.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks number women that had a mammogram in the reporting year by age cohort. Measure includes numerator for number of women with malignancy of the breast. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator(s): Female enrollees receiving at least one mammogram. Number of tests detecting malignancy. Denominator: Unduplicated female enrollees by age cohort. Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000)
Women's health measures: Pap test (cervical cancer screening).	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks number women that had a Pap test in the reporting year by age cohort. Measure includes numerator for number of women with malignancy of the cervix and/or uterus. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Female enrollees receiving at least one Pap test. Number of tests detecting malignancy. Denominator: Unduplicated female enrollees by age cohort. Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000)

QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Child health measures: HealthCheck screens.	Trend and monitor utilization. Goal: 80% of eligible children under age 21 receive required screens. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of children that received a comprehensive HealthCheck screening by age cohort. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Number of unduplicated children under age 21 that received at least one comprehensive HealthCheck. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000)
Child health measures: HealthCheck screens.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks number children referred for follow-up care as the result of HealthCheck screens, excluding vision, dental and audiology services by age cohort under age 21 years. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Children referred for follow-up care as the result of HealthCheck screens, excluding vision, dental and audiology services by age cohort under age 21 years. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000).

QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Child health measures: well-child non-HealthCheck screens.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of children that received a child health non-HealthCheck screening by age cohort under age 21 years. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: The number of children that received a child health non-HealthCheck screening by age cohort under age 21 years. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000)
Child health measures: other non-HealthCheck ambulatory health services.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of children that received a non-HealthCheck ambulatory health service by age cohort under age 21 years. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: The number of children that received a non-HealthCheck ambulatory health service by age cohort under age 21 years. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000)

QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Child health measures: number of children with diagnosis of asthma.	Trend and monitor prevalence. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of unduplicated enrollees under age 21 years with diagnosis of asthma in the reporting period. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees under age 21 years with diagnosis of asthma. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000).
Child health measures: number of children with at least one inpatient stay for a diagnosis of asthma.	Trend and monitor prevalence and utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts	Tracks the number of unduplicated enrollees under age 21 years with at least one inpatient stay for a diagnosis of asthma in the reporting period. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees with at least one inpatient stay for a diagnosis of asthma. Denominator: All enrollees under age 21 years with diagnosis of asthma. Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000).

QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Mental health/ substance abuse: outpatient evaluations.	Trend and monitor prevalence and utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of unduplicated enrollees receiving outpatient mental health and/or substance abuse evaluations by age cohort. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees receiving outpatient mental health and/or substance abuse evaluations. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000).
Mental health/ substance abuse: outpatient treatment.	Trend and monitor prevalence and utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of unduplicated enrollees receiving outpatient mental health and/or substance abuse treatment by age cohort. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator(s): Unduplicated enrollees receiving outpatient mental health and/or substance abuse treatment. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000).

QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Mental health/ substance abuse: inpatient readmissions for treatment.	Trend and monitor prevalence and utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of unduplicated enrollees receiving inpatient mental health for the same diagnosis within one year by age cohort. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees receiving inpatient mental health for the same diagnosis within one year. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000).
Primary and Specialty care: ER visits without inpatient admission.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of unduplicated enrollees receiving care in an emergency department of an acute care hospital not resulting in an inpatient admission by age cohort. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees receiving care in an emergency department of an acute care hospital not resulting in an inpatient admission. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000).

QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Primary and Specialty care: Home care	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of unduplicated enrollees receiving care in a home care setting by age cohort. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees receiving care in a home care setting. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000).
Primary and Specialty care: Care in a primary care clinic, vision care, audiology, and dental clinic.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of unduplicated enrollees receiving care in each listed care setting. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees receiving care in each listed care setting. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000)

QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Hospital utilization data: number of discharges, ALOS, total hospital days, for maternity, surgical, medical, psychiatric and AODA services.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of unduplicated enrollees receiving care in an inpatient acute care hospital setting for each listed care type. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees receiving care in an inpatient acute care hospital setting for each listed care type. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented. Data for 1st 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000)

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

☒ Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: BadgerCare

Date enrollment began (i.e., when children first became eligible to receive services): 4/1/99 for 1905(u)(3) children, 7/1/99 for 1905(u)2) children

☐ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program:

Date enrollment began (i.e., when children first became eligible to receive services):

☒ Other - Family Coverage

Name of program: BadgerCare - Health Insurance Premium Payment (HIPP) program

Date enrollment began (i.e., when children first became eligible to receive services): October 1, 1999

Note: Family Coverage, or HIPP, provided to cases that are either all BadgerCare case members, or cases that have a mixture of both BadgerCare and Medicaid case members. Wraparound services up to the Medicaid benefit level are provided. For more detail, please refer to Section 2.1.2 of this report.

☒ Other - Employer-sponsored Insurance Coverage

Name of program: BadgerCare - Health Insurance Premium Payment (HIPP) program

Date enrollment began (i.e., when children first became eligible to receive services): October 1, 1999

Note: ESI, or HIPP, provided to cases that are either all BadgerCare case members, or cases that have a mixture of both BadgerCare and Medicaid case members. Wraparound services up to the Medicaid benefit level are provided. For more detail, please refer to Section 2.1.2 of this report.

☐ Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

☒ Other (specify) Section 1115 Demonstration Waiver to cover adults who are custodial parents/spouses of custodial parents of BadgerCare children with Title XIX funding

Name of program: BadgerCare

Date enrollment began (i.e., when children first became eligible to receive services): July 1, 1999

2.1.2 If State offers family coverage: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

EDS, the Wisconsin Medicaid fiscal agent, receives daily notifications of the employment status of new and ongoing BadgerCare recipients from the state's eligibility determination (CARES) system. EDS contacts the employers of all applicants to verify for current access to family health insurance subsidized by the employer. Verification is done through mailing Employer Verification of Insurance Coverage (EVIC) forms to the employers and telephone follow-up.

The Heath Insurance Premium Payment (HIPP) Program -- Cost-Effectiveness Test.

At this point, EDS has received verification that the family has access to employer-subsidized family health care coverage, subsidized at less than 80 percent but more than 60 percent of the premium cost. The family is made BadgerCare eligible on a FFS basis. The next step is to determine whether it is cost-effective to buy them into the available employer-sponsored insurance through the HIPP Program or through the Title XXI cost-effectiveness test. If it is not cost-effective, the family chooses between the BadgerCare HMO programs available to recipients living in their service area or remain in BadgerCare FFS if

no HMOs are available. If only one HMO is available the family has a choice between choosing to enroll in the HMO or remaining in FFS.

Employers are contacted to obtain specific information about their insurance plans so that:

- Cost effectiveness can be determined. EDS determines the cost of the family premium, how much the employer pays, and what types of services the plan covers.

- Premium payments can be made. EDS determines whether the employer, insurer or recipient will be reimbursed, as well as frequency and payment method.

- Full insurance information is added to the recipient's eligibility record for coordination of benefits activities in claims processing. This information includes group and subscriber numbers, begin and end dates of coverage and indicators of services covered by the plan.

- The following information is collected and retained in the HIPP Program database:

  - Length of employer health insurance coverage;

  - Employer payment frequency and method of payment;

  - Premium amounts;

  - Employer contribution amounts and coverage; and

  - Who is covered under the insurance.

- BadgerCare families in Wisconsin are only eligible to participate in HIPP if:

  - they had no employer-sponsored group coverage within the previous six months (exceptions are allowed if prior coverage was involuntarily terminated by other than the current employer), and

  - the employer contributes at least 60 percent, but less than 80 percent, of the premium share for family coverage (families whose employer contributes more than 80 percent of the premium share are not eligible for BadgerCare).

- When the information needed for the cost-effectiveness determination is received, the cost effectiveness comparison is made between:

- The cost of BadgerCare HMO enrollment for the children (plus certain additional services covered on a FFS basis, such as family planning, dental, or chiropractic), up to the full Medicaid level of services; and

- The cost of the BadgerCare portion of the employer-subsidized insurance premium (including the cost of co-insurance and deductible reimbursement to the providers), plus the cost of wraparound services to provide the full Medicaid level of services. In addition, the state includes administrative costs for data collection, processing, notifications, telephone charges and other maintenance costs of the HIPP process in its cost effectiveness calculation.

- If cost of ESI is less than enrollment of children only in BadgerCare, the state claims cost for purchase of ESI under Title XXI for adults.

Another calculation is made to compare costs of ESI vs. enrollment of the family in BadgerCare. If ESI is less expensive, the state charges adults at regular FMAP.

The Health Insurance Premium Payment (HIPP) Program - Benefits equivalency, Limitation on Copayment Liability, Coordination with CHIP

Benefit Equivalency: BadgerCare recipients receive the full range of Wisconsin Medicaid covered services. BadgerCare recipients enrolled in employer-sponsored insurance through HIPP also receive the full range of Wisconsin Medicaid covered services. Recipients enrolled in ESI receive BadgerCare services on a FFS basis from Medicaid providers for those services not covered by the ESI or services covered by the ESI but for which maximum limits have been reached. This is called "wraparound."

Limitation on Copayment Liability: BadgerCare recipients enrolled in employer-sponsored insurance through HIPP do not pay for the coinsurance and deductibles charged by the ESI. ESI providers submit claims for coinsurance and deductibles to EDS, the Wisconsin Medicaid fiscal agent, which are then paid on a FFS basis. BadgerCare recipients enrolled in employer-sponsored insurance are required to pay the standard Medicaid copayments, which are nominal. Medicaid copayments are only applied to non-pregnant adults; in addition, certain services are exempt from copayments which include emergency services, family planning services/supplies, therapies over the Medicaid prior authorization limit, and other essential services.

Coordination with CHIP: The family is enrolled in the employer-provided family health insurance plan at the earliest available open enrollment period of the health plan. If the earliest available open enrollment period is less than six months in the future, the family receives benefits in BadgerCare FFS until they can be enrolled in the employer-provided family health insurance plan. If the earliest available

open enrollment period is six or more months in the future, the family is enrolled in the Medicaid HMO program until they can be enrolled in the employer-provided family health insurance plan.

2.1.3 If State has a buy-in program for employer-sponsored insurance: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

See answer to 2.1.2. The buy-in program for employer-sponsored insurance (HIPP) is the same program as described in family coverage, with the exception of the nature of the cost-effectiveness test. If it is cost-effective to enroll the entire BadgerCare family into ESI compared to the cost of enrolling the whole family into BadgerCare HMOs, then buy-in occurs, with the adults receiving the regular Medicaid match rate.

2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

The pre-existing program that affected the design of BadgerCare was the Wisconsin Medicaid program. Medicaid affected the design of BadgerCare in the following aspects:

<u>BadgerCare Benchmark Benefit Package</u>

Wisconsin Medicaid covered services was the benefit package chosen for BadgerCare. There were a number of reasons for this decision. First, Wisconsin Medicaid has one of the most comprehensive benefit packages in the nation. All optional Medicaid services are covered except for Christian Science sanitarium services.

Second, using the Medicaid benefit package reduced the administrative complexity of implementing and maintaining BadgerCare. We knew in designing the BadgerCare program that there would be many families eligible for BadgerCare that would have some family members that were eligible for Medicaid. Recent data from March 2000 show that 55 percent of the current BadgerCare cases contain one or more family members that are eligible for Medicaid. Using a non-Medicaid benefit package for BadgerCare would have confused families about their coverage. Medicaid providers could have become confused about different coverage, especially Medicaid HMOs serving such mixed families. A non-Medicaid benefit package would have required extensive Medicaid Management Information System (MMIS) computer changes and extensive changes in provider notification materials.

<u>Service Delivery and Assuring Access to Care and Quality of Care</u>

Wisconsin Medicaid, prior to the implementation of BadgerCare, had a statewide managed care program for the AFDC-related/Healthy Start population. Eighteen Medicaid HMOs participate in this program. This managed care program has proved successful in improving the access to and quality of care compared to traditional Medicaid FFS. Medicaid HMO enrollees, compared to recipients in FFS, have higher rates of visits to primary care providers, higher immunization rates and well-child examinations for children, and lower rates of Cesarean sections and higher rates of Pap testing for women. There are also a comprehensive range of quality improvement activities undertaken in the managed care program - by HMOs, state staff, and state contractors. Based on this experience, we decided that the main form of service delivery for BadgerCare would be Medicaid HMOs.

Eligibility Determination/Redetermination and Coordination with Medicaid and Other Programs (i.e., private insurance and crowd-out)

Wisconsin Medicaid has an extensive statewide, automated, integrated eligibility determination system called Client Assistance for Reemployment and Economic Support (CARES). An eligibility worker collects family and financial data through an interactive interview prompted by CARES, which then determines eligibility by applying federal and state law for four programs (Medicaid, food stamps, child care and TANF) and generates the appropriate notices and benefits. Because the policy logic is built into the system, CARES prompts the worker to gather the correct data, and applies that data in a standardized and consistent way for each case, thereby assuring the integrity of the eligibility determination process.

Families who want to receive Medicaid can apply at the county department of social or human services, at the tribal or W-2 agency or at outstation sites.

We designed BadgerCare to use this Medicaid eligibility determination and redetermination system because it was less confusing to customers, more efficient to administer, and to assure compliance with federal requirements. BadgerCare was built upon the structure that supports the Medicaid program, with county workers processing applications, using the CARES system for the interactive interview and eligibility determination. This minimized administrative costs, and integrated the program delivery to families, who may have some family members who qualify for Medicaid coverage and some who qualify under the BadgerCare expansion. This allows coordination between Medicaid and BadgerCare, with applicants tested for Medicaid eligibility prior to being tested for BadgerCare.

This design feature allowed Wisconsin to standardize eligibility policy between BadgerCare and Medicaid to the extent possible, and facilitates the development of new intake options that offer alternatives to working parents. We plan to develop and offer the option of a simplified application that would be widely available and easily completed for families who prefer a mail-in application.

The pre-existing automated features of the Medicaid eligibility determination/ redetermination and enrollment process that were incorporated into BadgerCare included the following features:

- The CARES system and its automated interface with the Wisconsin Medicaid Management Information System (MMIS) provides automated support and integrates the Medicaid and BadgerCare eligibility determination processes.

- The CARES system was easily modified to ask key questions to quickly screen BadgerCare applicants for potential eligibility for Wisconsin Medicaid and to add a module to determine their eligibility for BadgerCare. Standard treatment of income for Medicaid was incorporated into BadgerCare eligibility determination - e.g., applying such income disregards as work expenses, child caring expenses, child support disregards.

- Standard CARES practices were incorporated and modified for use in BadgerCare eligibility determination. This includes the use of automated letters, simple forms, phone call follow-up, and automated matching to gather complete data, to verify data for applications, and to inform applicants of outcomes and program coverage decisions.

- Eligibility information for BadgerCare could be transmitted to the MMIS through the pre-existing CARES/MMIS Interface Subsystem, with minimal modifications. The MMIS uses the Medicaid eligibility data to issue ID cards, enroll families in HMOs, and process claims.

- The pre-existing CARES system and CARES/MMIS Interface Subsystem made it much easier to develop the premium collection system for BadgerCare recipients. BadgerCare families with income over 150 percent of the FPL are required to pay a monthly premium of 3 percent of net family income.

The CARES system maintains information on net family income for Medicaid and BadgerCare families. The system was modified to determine which families would be required to pay a premium, to establish the monthly premium amount, to determine the method of payment, and to transmit premium collection information to the Medicaid fiscal agent through the pre-existing CARES/MMIS interface. New procedures were developed to have the eligibility worker collect the first month's premium.

EDS had ongoing experience in sending to and collecting information from recipients and employers through the process of Medicaid insurance verification. It was administratively efficient to develop new procedures for EDS for the purpose of ongoing notification to BadgerCare recipients of premium amounts and payment due dates, notification to recipients of overdue premiums, and communication with recipients and employers to set up the method of premium payment: direct payment by the recipient, wage withholding through the employer, or electronic funds transfer from the recipient.

Persons who are currently covered, or who were covered 3 months prior to the month of application, by health insurance plans that meet the Health Insurance Portability and Accountability Act (HIPAA) standards are not eligible for BadgerCare. CARES was modified so that the eligibility worker would collect insurance information from the household and verify that any current or 3 month old coverage met the HIPAA standard.

In addition, EDS, Wisconsin Medicaid's fiscal agent, already had an ongoing system in place for Medicaid to check for unreported coverage through the automated insurance disclosure process. This process was incorporated into BadgerCare with only minor modification. EDS receives daily notifications of BadgerCare applicants from the CARES system through the CARES/MMIS interface. For new BadgerCare recipients, the system matches recipient IDs against the databases of health insurance companies. When previously unreported insurance coverage is discovered, and met the HIPAA standard, EDS was modified to send a report to the eligibility system.

Additional Crowd-Out Provisions

Wisconsin implemented an additional crowd-out provision for BadgerCare based on state statutes. Applicants are denied BadgerCare if they have access to employer-offered family health insurance where the employer pays 80 percent or more of the cost of the monthly premium. This is called the "access" provision. Wisconsin also developed a program to buy-in BadgerCare recipients to employer-sponsored insurance is situations where a recipient had access to employer-sponsored insurance where the employer paid between 60 percent to 80 percent of the premium costs and it was cost-effective to buy-in to the plan.

For these purposes, we integrated the BadgerCare program into the operations of the Wisconsin Medicaid fiscal agent. New procedures were developed for BadgerCare in which EDS contacts the employers of all new BadgerCare recipients to verify 1) current coverage or coverage within the previous three months of verify family health insurance meeting HIPAA standards, 2) for current access to employer-offered family health insurance subsidized by the employer at 80 percent or more of the premium cost, and 3) current access to employer-offered family health insurance subsidized by the employer between 60 percent and 80 percent of the premium cost. Verification is done through mailing the newly developed Employer Verification of Insurance Coverage (EVIC) forms to the employers. Telephone follow-up with employers occurs in order to ensure that complete information is obtained.

Coverage or access verified through the EVIC form is communicated back to the CARES eligibility determination system.

Outreach:

Integrating BadgerCare with Medicaid through changes in the CARES system, the CARES/MMIS interface, the MMIS, EDS and eligibility procedures allowed Wisconsin to combine our efforts in outreach and training. Training on BadgerCare eligibility determination procedures were given to the same eligibility workers that performed Medicaid eligibility determinations. Expanding outstations to increase applications of potentially eligible families affected both Medicaid and BadgerCare potential populations. Media campaigns for both Medicaid and BadgerCare were integrated. Eventually, the name "BadgerCare" will be used for both Medicaid and BadgerCare, reducing the "welfare stigma" associated with Medicaid.

W-2 Health Plan

The other pre-existing program that affected the design of our CHIP program was the proposed W-2 Health Plan, and the failure of that proposed program to receive federal approval.

Provisions of 1995 Wisconsin Act 289, which authorized the W-2 welfare reform program, also included a W-2 Health Plan. This health plan was designed to provide health care to low-income families, dependent children, and working parents who could not afford health insurance. The program was designed as a bridge to self-sufficiency, providing affordable health insurance to low-income and working families and that would provide a transition to private health insurance.

The program applied to persons in W-2 work programs and other low-income families, and was considered a key aspect of the W-2 welfare reform program.

Key provisions of the W-2 Health Plan were:

- Covered families (children and adults) with income through 165 percent FPL
- No asset test
- Sliding scale premiums
- Comprehensive benefit package

Wisconsin realized that an affordable health plan that covered families was necessary as a support for W-2 and to meet the need of uninsured families.

When the W-2 Health Plan federal waivers were denied, the same principles of family coverage, support for W-2, and encouragement of the enrollment of children were applied to the design of BadgerCare.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

☐ No pre-existing programs were "State-only"

☒ One or more pre-existing programs were "State only." Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

There are 3 main "State only" health programs in Wisconsin. WisconCare is a small program in 17 counties with high unemployment rates that provides a limited scope of outpatient primary care and inpatient maternity/delivery services. Eligibility is based on unemployment or employment of less than 25 hours per week with income less than 150 percent FPL. Persons are not eligible if they are eligible for Medicaid, BadgerCare, or private insurance. Approximately 1,500 persons are enrolled.

General Relief medical care is a state funded program provided by some counties at their discretion. Certain medical/dental care is provided. Eligibility criteria are set by participating counties. Individuals cannot be eligible for Medicaid/BadgerCare. Approximately 26,000 persons are enrolled.

HIRSP (Health Insurance Risk Sharing Program) is a state funded program to provide health insurance to persons that cannot get private health insurance or are not eligible for Medicaid or BadgerCare. A fairly high level of premiums are required for recipients enrolled. There were 7,768 enrolled in HIRSP in November 1999. Only about 250 children are currently enrolled in HIRSP. Given the high level of premiums required for HIRSP the number of children enrolled in HIRSP has always been at this level, and they represent children from higher income families.

BadgerCare has not supplanted these programs. The three state-only programs above have very few children as a proportion of their total enrollment and in comparison to the numbers of children that have enrolled in BadgerCare.

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

☒ Changes to the Medicaid program:

- ☐ Presumptive eligibility for children
- ☐ Coverage of Supplemental Security Income (SSI) children
- ☐ Provision of continuous coverage (specify number of months)
- ☐ Elimination of assets tests
- ☐ Elimination of face-to-face eligibility interviews
- ☐ Easing of documentation requirements
- ☒ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify) _____

Narrative: The number of family Medicaid recipients decreased from 296,000 in December 1995 to 220,000 in December 1997. This period coincides with the phasing out of AFDC and the implementation of Wisconsin Works (W-2). The family Medicaid caseload stabilized in late 1997 and in 1998. From January 1998 to June 1999, the number of recipients ranged between 215,000 and 221,000.

The stabilization was the result of a concerted statewide outreach effort.

The combined Medicaid/BadgerCare caseload has increased significantly since mid-1999 with the implementation of BadgerCare. The combined family Medicaid/BadgerCare caseload increased from 222,000 recipients in July 1999 to 275,424 in February 2000.

Statewide outreach efforts for both Medicaid and BadgerCare, including training, TV ads, and agency collaboration contributed to this growth.

There has been a similar trend affecting Medicaid Healthy Start children (children under 6 with income up to 185 percent of the FPL; children born after September 30, 1983, with income under 100 percent of the FPL). From June 1998 to June 1999, the year before BadgerCare implementation, Healthy Start enrollment remained constant at approximately 66,900.

During the period July 1999 to January 2000 (with Medicaid outreach followed by BadgerCare implementation in July) the number of children enrolled in Healthy Start climbed from 66,283 to 75,076. After BadgerCare, Healthy Start enrollment began to rise by 1,000 recipients a month. By February 2000, Healthy Start enrollment was up to 82,970.

The increased Healthy Start enrollment has been positively affected by increased applications due to the interest in BadgerCare.

☒ Other (specify) Change in Period for Redetermination

Note: At the time of implementation of BadgerCare, in July 1999, we changed the review period for Medicaid from 6 months to 12 months, the same as for BadgerCare. This is not the same as continuous coverage, since income/asset changes occurring between the review period need to be reported and can change eligibility for benefits.

☒ Other (specify) Relaxing Requirements for a Face-to-Face Interview in Certain Circumstances

Narrative: Somewhat earlier than the implementation of BadgerCare, the Food Stamp program began to allow reviews of eligibility by telephone, and we are accepting such telephone reviews as applicable as a review for the Medicaid program.

Also, with the implementation of the BadgerCare program, we allowed some reduction in the requirements for face-to-face requirements for BadgerCare applicants. For those persons who already had a family member eligible for Medicaid and therefore were on the CARES system, and who requested a review of the case earlier than the scheduled review for purposes of a BadgerCare eligibility determination, we sent out a one page BadgerCare request form that could be filled out by the family and mailed back to the county. County agencies then reviewed the completed request form and could determine BadgerCare eligibility for the case without the need of a face-to-face interview.

Future plans for Medicaid/BadgerCare include mail-in, phone-in applications with a reduction in the need for face-to-face interviews.

☒ Other (specify) Future Plans to Ease Documentation

Narrative: Future plans for Medicaid/BadgerCare include a reengineering of the verification functions in CARES so that verification/documentation tasks can be streamlined.

☒ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

☒ Health insurance premium rate increases

No data is available yet for Wisconsin health insurance premium rate increases from July 1999 to September 1999. In the period immediately proceeding the implementation of BadgerCare (comparing July 1999 to July 1998), the following premium rate increases occurred, based on statistics gathered by the Wisconsin Office of the Commissioner of Insurance:

Monthly Rates	Ave. Increase: 7/98 to 7/99
Family Coverage, 25 Employees, Milwaukee	7.4%
Family Coverage, 75 Employees, Milwaukee	9.0%
Family Coverage, 75 Employees, Wis. Rapids	9.3%

Source: http://badger.state.wi.us/agencies/oci/pub_list/pi-081.htm

☒ Legal or regulatory changes related to insurance

Narrative: The July 1999 - June 2001 Biennial Budget (1999 Wisconsin 9, passed October 9, 1999) authorized the design and operation of a private employer health care program. The legislation provides infrastructure to create a new risk pool for small business employers to purchase group health insurance for their employees. Small businesses are more likely to be affected by small group rating practices, including premium increases, and often lack the stability and capacity to administer employee benefit programs. The intent of the legislation is to increase the availability of affordable group health insurance to employees in small firms.

☐ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)

☒ Changes in employee cost-sharing for insurance

Narrative: There are no recent studies in Wisconsin of trends in employee cost-sharing other than the increase in premium costs described above. However, anecdotal evidence from state purchasing groups, quality improvement organizations, etc. indicate that copayments, coinsurance, and deductibles are increasing for employer-offered health insurance plans.

The issue of employee-employer cost-sharing changes will be addressed in the Department's planned evaluation of BadgerCare.

☐ Availability of subsidies for adult coverage

☒ Other (specify) Wisconsin Uninsurance Rates
The Wisconsin Family Health Survey is performed annually, and surveys 2,000 Wisconsin residents per year on the extent of their

health insurance, health status, and utilization. In 1997, 5 percent of Wisconsin residents were uninsured for the entire 12 months. In 1998, the rate was 4 percent. Data is not yet available for 1999. The overall trend health of insurance rates in Wisconsin is positive .

☐ Changes in the delivery system:

- ☐ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
- ☐ Changes in hospital marketplace (e.g., closure, conversion, merger)
- ☐ Other (specify) _____

☐ Development of new health care programs or services for targeted low-income children (specify) _____

☒ Changes in the demographic or socioeconomic context:

- ☐ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify) _____
- ☒ Changes in economic circumstances, such as unemployment rate (specify) _____

  The Wisconsin unemployment rate in 1998 was 3.4 percent; projected unemployment in 1999 is 3.0 percent. Source: US Department of Labor.

- ☐ Other (specify) _____
- ☐ Other (specify) _____

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

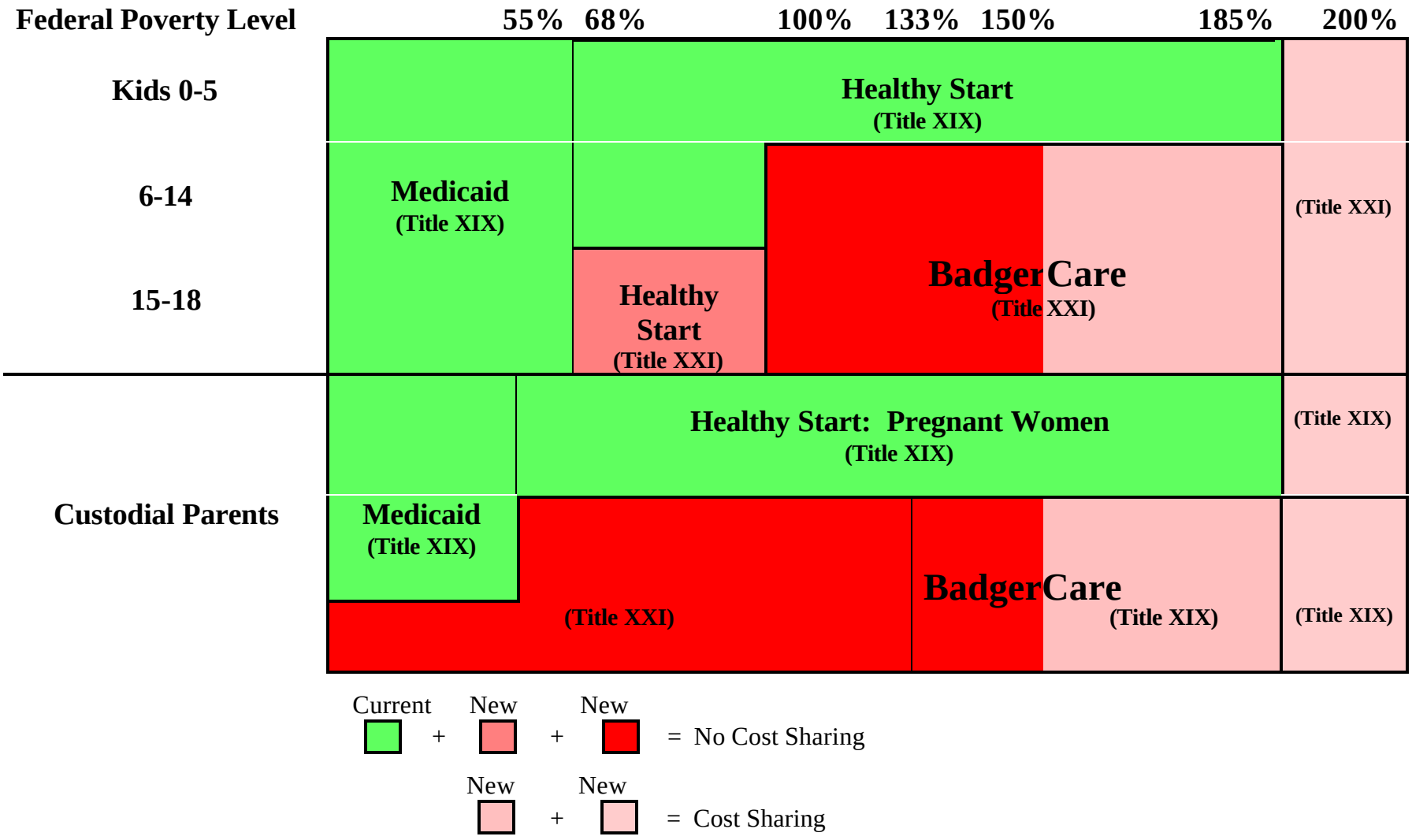
3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Please see next pages for tables 3.1.1 and the addenda tables to 3.1.1.

In addition, prior to those tables, please see the following page for an overall picture of current Wisconsin Medicaid and BadgerCare income eligibility requirements for children and adults.

Current Wisconsin Medicaid And BadgerCare



Developed by the National Academy for State Health Policy

Table 3.1.1					
	Medicaid CHIP Expansion Program	**State-designed CHIP Program**	**Other CHIP Program* Parents (Section 1115 Medicaid Waiver)**	**Other CHIP Program* ESI 1st made eligible for BadgerCare, then determine eligibility for ESI**	**Other CHIP Program* Family Coverage 1st made eligible for BadgerCare, then determine eligibility for Family Coverage**
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	Statewide		Statewide	Same	Same
Age	< 19 yrs. old		No age limit, custodial Parents or custodial spouse	Entire family	Entire family
Income (define countable income)	0-185% FPL Applicants 0-200% FPL Recipients		0-185% FPL Applicants 0-200% FPL Recipients	Same	Same
Resources (including any standards relating to spend downs and disposition of resources)	NA		NA	NA	NA
Residency requirements	State Resident And Migrants		State Resident And Migrants	State Resident And Migrants	State Resident And Migrants
Disability status	NA		NA	NA	NA

* Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column."

Table 3.1.1					
	Medicaid CHIP Expansion Program	**State-designed CHIP Program**	**Other CHIP Program* Parents (Section 1115 Medicaid Waiver)**	**Other CHIP Program* ESI 1st made eligible for BadgerCare, then determine eligibility for ESI**	**Other CHIP Program* Family Coverage 1st made eligible for BadgerCare, then determine eligibility for Family Coverage**
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	1. Not covered at time of the application or previous 3 mos.		1. Not covered at time of the application or previous 3 mos.	Same	Same
	2. No access during the last 18 mos. to employer-sponsored family group health plan where employer pays 80% or more of the family premium		2. No access during the last 18 mos. to employer-sponsored family group health plan where employer pays 80% or more of the family premium		
Other standards (identify and describe)				1. Access to ESI 2. Employer pays 60-80% 3. Not covered by ESI in previous 6 months 4. ESI for family less expensive than BC HMO for family	1. Access to ESI 2. Employer pays 60-80% 3. Not covered by ESI in previous 6 months 4. ESI for family less expensive than BC HMO for children only

* Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column."

Addendum to Table 3.1.1

The following questions and tables are designed to assist states in reporting countable income levels for their Medicaid and SCHIP programs and included in the NASHP SCHIP Evaluation Framework (Table 3.1.1). This technical assistance document is intended to help states present this extremely complex information in a structured format.

The questions below ask for countable income levels for your Title XXI programs (Medicaid SCHIP expansion and State-designed SCHIP program), as well as for the Title XIX child poverty-related groups. Please report your eligibility criteria as of September 30, 1999. Also, if the rules are the same for each program, we ask that you enter duplicate information in each column to facilitate analysis across states and across programs.

If you have not completed the Medicaid (Title XIX) portion for the following information and have passed it along to Medicaid, please check here **9** and indicate who you passed it along to.

Name _____, phone/e-mail _____

3.1.1.1 For each program, do you use a gross income test or a net income test or both?

Title XIX Child Poverty-related Groups	☐ Gross ☐ Both	☒ Net
Title XXI Medicaid SCHIP Expansion	☐ Gross ☐ Both	☒ Net
Title XXI State-Designed SCHIP Program	☐ Gross ☐ Both	☐ Net
Other SCHIP program_____	☐ Gross ☐ Both	☐ Net

3.1.1.2 What was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately.

Title XIX Child Poverty-related Groups:

185% of FPL for children under age 6
100% of FPL for children aged 6 to under age 19
____% of FPL for children aged _____

Title XXI Medicaid SCHIP Expansion:

185% of FPL for children aged under age 19 (who are applicants)
200% of FPL for children aged under age 19 (who are recipients)
____% of FPL for children aged _____

Title XXI State-Designed SCHIP Program:

____% of FPL for children aged _____
____% of FPL for children aged _____
____% of FPL for children aged _____

Other SCHIP program _____

____% of FPL for children aged _____
____% of FPL for children aged _____
____% of FPL for children aged _____

3.1.1.3 Complete Table 1.1.1.3 to show whose income you count when determining eligibility for each program and which household members are counted when determining eligibility? (In households with multiple family units, refer to unit with applicant child)

Enter "Y" for yes, "N" for no, or "D" if it depends on the individual circumstances of the case.

Table 3.1.1.3				
Family Composition	**Title XIX Child Poverty-related Groups**	**Title XXI Medicaid SCHIP Expansion**	**Title XXI State-designed SCHIP Program**	**Other SCHIP Program* _____**
Child, siblings, and legally responsible adults living in the household	Y	Y		
All relatives living in the household	N	N		
All individuals living in the household	N	N		
Other (specify)				

3.1.1.4 How do you define countable income? For each type of income please indicate whether it is counted, not counted or not recorded.

Enter "C" for counted, "NC" for not counted and "NR" for not recorded.

Table 3.1.1.4				
Type of Income	**Title XIX Child Poverty-related Groups**	**Title XXI Medicaid SCHIP Expansion**	**Title XXI State-designed SCHIP Program**	**Other SCHIP Program* _____**
Earnings Earnings of dependent children	NC- Not counted if under age 16	NC- Not counted if under age 16		
Earnings of students	NC – not counted if full time student up to age 19	NC – not counted if full time student up to age 19		
Earnings from job placement programs	C	C		

* Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column."

Table 3.1.1.4				
Type of Income	**Title XIX Child Poverty-related Groups**	**Title XXI Medicaid SCHIP Expansion**	**Title XXI State-designed SCHIP Program**	**Other SCHIP Program*** **_____**
Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America)	C	C		
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	C	C		
Education Related Income Income from college work-study programs	C	C		
Assistance from programs administered by the Department of Education	C	C		
Education loans and awards	NC	NC		
Other Income Earned income tax credit (EITC)	NC	NC		
Alimony payments received	C	C		
Child support payments received	C (with $50 disregarded)	C (with $50 disre-garded)		
Roomer/boarder income	C	C		
Income from individual development accounts	C	C		
Gifts	C	C		
In-kind income	NC	NC		
Program Benefits Welfare cash benefits (TANF)	NC	NC		
Supplemental Security Income (SSI) cash benefits	NC	NC		

* Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column."

Table 3.1.1.4				
Type of Income	**Title XIX Child Poverty-related Groups**	**Title XXI Medicaid SCHIP Expansion**	**Title XXI State-designed SCHIP Program**	**Other SCHIP Program*** **_____**
Social Security cash benefits	C	C		
Housing subsidies	NC	NC		
Foster care cash benefits	NC	NC		
Adoption assistance cash benefits	NC	NC		
Veterans benefits	C	C		
Emergency or disaster relief benefits	C	C		
Low income energy assistance payments	NC	NC		
Native American tribal benefits	C	C		
Other Types of Income (specify)				

3.1.1.5 What types and amounts of disregards and deductions does each program use to arrive at total countable income?

Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA."

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ☐ Yes ☐ No

If yes, please report rules for applicants (initial enrollment).

* Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column."

Table 3.1.1.5				
Type of Disregard/Deduction	**Title XIX Child Poverty-related Groups**	**Title XXI Medicaid SCHIP Expansion**	**Title XXI State-designed SCHIP Program**	**Other SCHIP Program* _____**
Earnings	$90	$90	$	$
Self-employment expenses	$	$	$	$
Alimony payments Received	$	$	$	$
Paid	$	$	$	$
Child support payments Received	$50	$50	$	$
Paid	$	$	$	$
Child care expenses	$175/200	$175/200	$	$
Medical care expenses	$	$	$	$
Gifts	$	$	$	$
Other types of disregards/ deductions (specify)	$	$	$	$

3.1.1.6 For each program, do you use an asset or resource test?

Title XIX Poverty-related Groups:

☒ No ☐ Yes (complete column A in 3.1.1.7)

Title XXI SCHIP Expansion program:

☒ No ☐ Yes (complete column B in 3.1.1.7)

Title XXI State-Designed SCHIP program:

☐ No ☐ Yes (complete column C in 3.1.1.7)

* Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column."

Other SCHIP program _____

☐ No ☐ Yes (complete column D in 3.1.1.7)

3.1.1.7 How do you treat assets/resources?

Please indicate the countable or allowable level for the asset/resource test for each program and describe the disregard for vehicles. If not applicable, enter "NA."

Table 3.1.1.7

Treatment of Assets/Resources	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Countable or allowable level of asset/resource test	$NA	$NA	$	$
Treatment of vehicles: Are one or more vehicles disregarded? *Yes or No*				
What is the value of the disregard for vehicles?	$NA	$NA	$	$
When the value exceeds the limit, is the child ineligible("I") or is the excess applied ("A") to the threshold allowable amount for other assets? *(Enter I or A)*				

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999?

☐ Yes ☒ No

3.1.2 How often is eligibility redetermined?

* Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column."

Table 3.1.2					
	Medicaid CHIP Expansion Program	**State-designed CHIP Program**	**Other CHIP Program* Parents (Section 1115 Medicaid Waiver)**	**Other CHIP Program* ESI 1st made eligible for BadgerCare, then determine eligibility for ESI**	**Other CHIP Program* Family Coverage 1st made eligible for BadgerCare, then determine eligibility for Family Coverage**
Monthly					
Every six months					
Every twelve months[1]	X		X	X	X
Other (specify)					

* Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column."

[1] At the time of implementation of BadgerCare, in July 1999, we changed the review period for Medicaid from 6 months to 12 months, the same as for BadgerCare. This is not the same as continuous coverage, since income/asset changes occurring between the review period need to be reported and can change eligibility for benefits.

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

☐ Yes Which program(s)? _____

For how long? _____

☒ No

3.1.4 Does the CHIP program provide retroactive eligibility?

☐ Yes Which program(s)? _____

How many months look-back? _____

☒ No

3.1.5 Does the CHIP program have presumptive eligibility?

☐ Yes Which program(s)? _____

Which populations? _____

Who determines? _____

☒ No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

☒ Yes Is the joint application used to determine eligibility for other State programs? If yes, specify. Child care, food stamps, W-2 (TANF)

☐ No

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

Wisconsin's BadgerCare eligibility determination process has the following strengths in increasing creditable health coverage among targeted low-income children:

- Wisconsin's automated public assistance eligibility system, CARES, determines the eligibility for all Medicaid subprograms, including the Medicaid expansion through BadgerCare that are administered by the local economic support agencies. We call the set of logical steps taken by the system to test for eligibility for each Medicaid subprogram the

'Medicaid Cascade.' The Medicaid Cascade, when modified to include BadgerCare, was able to test new applicants, as well as persons losing Medicaid eligibility, for BadgerCare eligibility without any separate action by the worker or the customer.

- In addition, because CARES determines eligibility for Food Stamps, Child Care and Temporary Assistance to Needy Families, CARES was able to automatically determine the Medicaid and BadgerCare eligibility of persons who applied for, reported changes, had a redetermination or a termination of eligibility for these un-related programs.

- More than 55 percent of those individuals now enrolled in BadgerCare were in CARES as the parents, spouses and older siblings of eligible children and pregnant women. Simply by supplying a minimum amount of information specific to BadgerCare eligibility, BadgerCare eligibility could be determined.

- CARES also had up-to-date information on the insurance coverage of existing Medicaid recipients through an interface with the Medicaid Management Information System (MMIS). By Wisconsin law, MMIS is sent an electronic record of each person in Wisconsin who is covered by a private health insurance carrier. This allowed the state to know at the time of the eligibility determination, from a third party source, whether the individual was currently covered by private health insurance and therefore was not eligible to receive BadgerCare.

The major weakness of Wisconsin's eligibility determination system was our lack of experience with a premium collection system. We found that it was difficult to coordinate eligibility requirements and the collection of the BadgerCare premium for families with incomes greater than 150 percent FPL.

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

Wisconsin's redetermination process does not require a face-to-face interview. Recipients are not required to verify any information that does not change over time (date of birth, SSN, etc.).

Wisconsin's eligibility redetermination process is as transparent and easy to use for the customer as is possible from an automated systems perspective. A separate CARES function allows the worker to review current eligibility information with the recipient, updating information when changes have occurred. With the Medicaid Cascade, even when new information can mean a change in subprogram eligibility, all other Medicaid subprogram requirements are checked

to see if the family members can remain Medicaid or BadgerCare eligible based upon the new information.

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

Table 3.2.1 *CHIP Program Type* _Medicaid Expansion_, Section 1115 Medicaid Waiver Parents, ESI, Family Coverage			
Benefit	**Is Service Covered? (T = yes)**	**Cost-Sharing (Specify) [Co-pays are just for adults and are not required of people served through managed care]**	**Benefit Limits (Specify)**
Inpatient hospital services	T	$3.00 per day, up to $75.00 per stay	
Emergency hospital services	T		
Outpatient hospital services	T	$3.00 per visit	
Physician services	T	$1.00 to $3.00 per service	
Clinic services	T	$2.00 per visit	
Prescription drugs	T	$1.00, new and refilled prescriptions up to $5.00 per pharmacy per month	
Over-the-counter medications	T	$0.50 per each prescription (no monthly limit)	
Outpatient laboratory and radiology services	T	$1.00 to $3.00 per service	
Prenatal care	T		
Family planning services	T		
Inpatient mental health services	T	Varies by services ($0.50-$3.00)	
Outpatient mental health services	T	Varies by services ($0.50-$3.00)	
Inpatient substance abuse treatment services	T	$3.00 per day, up to $75.00 per stay	
Residential substance abuse treatment services	T		
Outpatient substance abuse treatment services	T	Varies by services ($0.50-$3.00)	
Durable medical equipment	T	Varies by Item ($0,50 to $3.00 per item)	
Disposable medical supplies	T		

Table 3.2.1 *CHIP Program Type* _Medicaid Expansion_, Section 1115 Medicaid Waiver Parents, ESI, Family Coverage			
Benefit	**Is Service Covered? (T = yes)**	**Cost-Sharing (Specify) [Co-pays are just for adults and are not required of people served through managed care]**	**Benefit Limits (Specify)**
Preventive dental services	T	Varies by service ($0.50 to $3.00 per proc.)	
Restorative dental services	T	Varies by service ($0.50 to $3.00 per proc.)	
Hearing screening	T	$1.00 per service	
Hearing aids	T	$3.00 per item	
Vision screening	T		
Corrective lenses (including eyeglasses)	T	New frame-$3.00 Lens or Temple replace.-$2.00	
Developmental assessment	T		
Immunizations	T		
Well-baby visits	T		
Well-child visits	T		
Physical therapy	T		
Speech therapy	T		
Occupational therapy	T		
Physical rehabilitation services	T		
Pediatric services	T	$1.00 to $3.00 per visit/service	
Chiropractic services	T	$1.00 to $3.00 per visit/procedure	
Medical transportation	T	Non-emergency ambulance-$2.00 per trip. SMV-$2.00 per base rate	
Home health services	T		

Table 3.2.1 ***CHIP Program Type*** _Medicaid Expansion_, Section 1115 Medicaid Waiver Parents, ESI, Family Coverage			
Benefit	**Is Service Covered? (T = yes)**	**Cost-Sharing (Specify) [Co-pays are just for adults and are not required of people served through managed care]**	**Benefit Limits (Specify)**
Nursing facility	T		
ICF/MR	T		
Hospice care	T		
Private duty nursing	T		
Personal care services	T		
Habilitative services	T		
Case management/Care coordination	T		
Non-emergency transportation	T	$2.00 per trip	
Interpreter services	T		
Other (Specify)			
Other (Specify)			
Other (Specify)			

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

Medical Benefits

Overview of Types of Medical Benefits

Wisconsin Medicaid currently covers a comprehensive set of medical services. This includes all mandatory Medicaid services and all optional Medicaid services (except for Christian Science sanatorium services). BadgerCare covers the same comprehensive set of medical services. These Medicaid services are available to all BadgerCare recipients in the Medicaid FFS program.

Medicaid/BadgerCare Services Provided by Medicaid/BadgerCare HMOs and Included in the Capitation Rates, and Those Otherwise Reimbursed, Including Family Planning

BadgerCare HMOs are required to cover the full range of Medicaid/BadgerCare services, which are included in the HMO capitation rates, with the following exceptions that are reimbursed on a FFS or other basis:

- Transportation by common carrier or private motor vehicle if authorized by county departments of social or human services.

  Common carrier/private motor vehicle transportation to and from medical appointments is authorized and paid for by local county departments of social or human services funded through a separate account for local services. HMOs are encouraged to have MOUs with local county agencies whereby HMOs can provide assistance for common carrier/private motor vehicle transportation and be reimbursed, in turn, by the county agency.

- Family Planning Services.

  Family planning services must be provided by HMOs and are included in the capitation rate.

  However, HMO BadgerCare enrollees are allowed to receive family planning services at non-HMO affiliated Family Planning Clinics. These

non-affiliated Family Planning Clinics may be reimbursed on a Medicaid FFS basis.

In addition, the BadgerCare HMO contract requires that enrollees who are minors be given the opportunity to have their own primary physician for the provision of family planning services, separate from the primary provider chosen by or assigned to the enrollee or enrollee family.

- Prenatal Care Coordination Services.

  As with Medicaid, prenatal care coordination services are paid on a FFS basis and are not included in the BadgerCare HMO capitation rates.

- Targeted Case Management Services.

  As with Medicaid, targeted case management services are paid on a FFS basis and are not included in the BadgerCare HMO capitation rates.

- Dental Services.

  Dental services in 68 Wisconsin counties are excluded from BadgerCare HMO capitation rates, and BadgerCare HMO enrollees in these counties receive dental services on a FFS basis.

  Dental service is covered by most HMOs in Kenosha, Milwaukee, Racine, and Waukesha counties. This means that most BadgerCare HMOs serving those counties choose to cover dental services. Their capitation rates are increased with a dental services add-on. If they choose not to cover dental services, BadgerCare HMO enrollees receive dental services on a FFS basis.

- Chiropractic Services.

  Chiropractic service is an optional service for BadgerCare HMOs statewide. This means that BadgerCare HMOs may choose to cover chiropractic services or choose not to cover chiropractic services. If they choose to cover chiropractic services their capitation rates are increased with a chiropractic services add-on. If they choose not to cover chiropractic services, BadgerCare HMO enrollees receive chiropractic services on a FFS basis.

Preventative Services

The major preventive services in the Medicaid/BadgerCare benefit package include the following:

- Immunizations
- HealthCheck Screening
- Pre-natal Care Coordination

The primary delivery system for BadgerCare is the Medicaid HMO program. BadgerCare HMOs must meet the following additional requirements for Medicaid preventive services:

- BadgerCare HMOs are required to perform HealthCheck screens at a rate equal to or greater than 80 percent of the expected number of screens. If the HMO provides fewer screens in the contract year than 80 percent, the Department recoups the funds provided to the HMO for the provision of the remaining screens.
- The HMOs are required to operate a program to promote full immunization of Medicaid recipients
- DHFS encourages HMOs to contract with local health departments for the provision of care to Medicaid recipients in order to assure continuity and culturally appropriate care and services. Local health departments can provide HealthCheck outreach and screening, immunization, blood lead screening services, and services to targeted populations within the community for the prevention, investigation, and control of communicable diseases.
- Health education and prevention is also required of BadgerCare HMOs. HMOs are required to:

    1. Inform all enrolles of contributions which they can make to the maintenance of their own health and the proper use of health care services.

    2. Have a program of health education and prevention available and within reasonable geographic proximity to its enrolles. The programs are to include health education and anticipatory guidance provided as a part of the normal course of office visits and in discrete programming.

- HMOs must sign MOUs with all agencies in the HMO service area who are Medicaid certified prenatal care coordination agencies. Additionally, the HMO assigns an HMO medical representative to work with the care coordinator from the prenatal care coordination agency. This HMO representative works with the care coordinator to identify what Medicaid covered services, in conjunction with other identified social services, are to be provided to the enrollee.

Special Health Care Needs

The term "children with special health care needs" means children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally and who are enrolled in a Children with Special Health Care Needs program operated by a Local Health Department or a local Title V-funded Maternal and Child Health Program.

Some Wisconsin Local Health Departments (LHDs) provide Medicaid reimbursed services for which HMOs may contract, such as:

- HealthCheck screening, outreach and follow-up;
- Immunizations;
- Blood lead screening;
- Extended case management of medical conditions such as asthma, diabetes, hypertension and children with special health care needs; and
- Home health and personal care services.

Throughout the state, the health care network includes many nonprofit community-based health organizations including: private HealthCheck providers, family planning clinics and WIC clinics. These organizations may provide some of the same Medicaid reimbursed services as LHDs. They may also have the same access to special populations as LHDs. BadgerCare HMOs are encouraged to contract with these community based health organizations.

Cost-Sharing

Premiums: Families with income above 150 percent of the FPL must pay a monthly premium of 3 percent of family net income. Premium shares are collected through wage withholding or an alternative, automated system. Only one premium share is assessed per family.

All populations currently eligible for Medicaid receive benefits without paying a premium share. These populations include:

- All AFDC-Medicaid and Healthy Start Medicaid eligible individuals;

- Low-income pregnant women and children under age six with family income less than 185 percent of the FPL (under Healthy Start); and

- Children up to age 15, who are born after September 30, 1993, in families with income less than 100 percent of the FPL (under Healthy Start). (Under BadgerCare, the age of children in this group would increase from 15 to 19.)

- Through the expansion, BadgerCare extends coverage with no premium share to all low-income families with children below 150 percent of the FPL.

Copayments: Non-pregnant BadgerCare adults in Medicaid fee-for-service have to pay a flat nominal copayment ranging from $.50 to $3 for some services. These are the same copayments required for the Medicaid program. Most services that have a copayment have a maximum after which the recipient is not required to make further copayments. Children and BadgerCare HMO enrollees are exempt from copayments.

The following services are exempted from copayments for BadgerCare non-pregnant adults in Medicaid FFS: nursing home services, emergency hospital and ambulance services, family planning services/supplies, SMV services, home health services, therapies over prior authorization limits, and other services.

There are no other types of cost-sharing in BadgerCare

Enabling Services for Current BadgerCare Recipients

A. Non-Emergency Transportation - Local economic support agencies are funded by the state to provide non-emergency common carrier/private vehicle transportation services to all Medicaid/BadgerCare recipients. Many Medicaid HMOs have arrangements with local county agencies to provide non-emergency common carrier transportation services to their BadgerCare enrollees and then in turn be reimbursed by the county agency.

B. Interpreter Services - Medicaid FFS providers and HMOs are required to provide necessary translation/interpreter services to Medicaid/ BadgerCare recipients in order that recipients can have full access to Medicaid benefits.

C. Targeted Case Management within MA Services - Specific BadgerCare recipients receive targeted case management services that assist the person, and, when appropriate, the person's family gain access to, and

coordinate or monitor necessary medical, social, educational, vocational and other services. Components of targeted case management include case assessment, case planning, and ongoing monitoring and service coordination.

The targeted populations for case management services include the developmentally disabled, under 21 and severely emotionally disturbed, and persons who are alcohol or drug dependent.

Enabling Services For Potential Applicants to BadgerCare

A. Translation Services - Translation services, operated by Latino Health Organization of Milwaukee – providing assistance to families in southeastern Wisconsin who speak Spanish, Hmong or Russian as their primary language to navigate the Medicaid/BadgerCare eligibility determination process.

Outreach brochures and posters for Medicaid and BadgerCare have been translated into Spanish and Hmong.

B. Direct Community Outreach to Specific Populations - The DHFS has initiated community outreach projects directed to specific populations, as part of the overall outreach strategy for Medicaid/BadgerCare. Such specific projects include the following:

- *Direct Mail*

  DHFS conducted a direct mail campaign in the spring of 1998 to 18,000 families whose AFDC case closed for reasons such as "family request" or "lack of review". Informational telephone surveys of the larger social service agencies provided information that the mailing did not have a significant impact on Medicaid applications. In addition, caseload data does not show any increase in applications during the time period of the mailing.

- *Community Organization Projects*

  Benefit counseling, operated by ABC for Health, Inc., a Madison-based advocacy organization; and dissemination of a successful outreach model, operated by ABC for Health, Inc. – this project will provide training and technical assistance statewide to community agencies to disseminate the lessons learned from a very successful Healthy Start outreach initiative in three rural counties in the northwestern part of the state. Evaluation of these efforts will be published.

- *Local Health Department Coordination*

Public Health Agency Demonstration Projects. Medicaid outreach funds were allocated by formula to 140 local public health agencies. The grants extended from July 1, 1998, to September 30, 1999. In addition, funding was also allocated to hire five regional outreach specialists. These regional staff were assigned to provide technical assistance to local efforts; work with schools to identify uninsured children; and monitor the local departments' contracts. The major work efforts of public health agencies were:

1. *BadgerCare "OBRA Teen" Campaign.* The Division of Public Health served as the state's lead agency in news media promotion of the April 1, 1999, start for extending BadgerCare to low-income teens. The DPH crafted a news release used by 11 newspapers statewide, with readerships of about 92,000. As of November, the enrollment category had exceeded 4,000.

2. *Healthy Start Outreach.* Outreach for Healthy Start, a marketing name for Medicaid coverage of certain pregnant women and children, reached all-time high enrollments for five consecutive months during the outreach funding period. Enrollment has risen by nearly 10 percent in 1999 and now exceeds 88,000. More than 412,000 Healthy Start brochures were distributed during the grant period.

3. *"Back to School" Initiative.* Promoting BadgerCare and Medicaid among Wisconsin's nearly 1 million school children, DPH staff pursued *promising* strategies favored by outreach advocates nationwide.

4. *Medicaid Outreach Funds Targeted to Immunization Activities.* Medicaid outreach funds were used by local health departments for education and outreach activities to educate and refer families involved in immunization for Medicaid eligibility.

The Immunization Program MA Outreach funds were used by local health departments (LHDs) for education and outreach activities. The focus of the activities were to educate the parents on the importance of on-schedule immunization for children and in doing so identify families that were MA eligible and advocate them into the MA system. LHDs used a wide variety of activities to accomplish these goals. Examples of these efforts include the development of educational materials to include MA information. Eligible families identified through the immunization clinic enrollment process were referred into the MA system. LHD staff did person to person contact to parents of behind schedule children to encourage them to make and keep immunization appointments and discussed MA eligibility when appropriate. Funds were used to train public health nurses regarding MA eligibility and access so they could better assist eligible clients. Interpreters were hired to do outreach activities to non-English speaking families. Staff was used to bridge the gap between WIC and MA. Outreach efforts were made to day care centers with high rates of low-income MA eligible families.

- *Problem Solving Services*

  The Medicaid/BadgerCare Recipient Services hotline (1-800-362-3002) operated by the state's fiscal agent now provides expanded services and new evening and weekend hours. In addition to general program information, callers get assistance in how and where to apply for Medicaid and BadgerCare and help in resolving case problems. Staff at the hotline provide trouble-shooting services and research case-specific problems, including computer systems issues. These services are now available weekdays until 9:00 p.m. and all day Saturday. The hotline averages about 1,000 calls each day.

  In addition to the statewide services, specialized services for customers in Milwaukee County are being offered during the start-up of BadgerCare. Staff at the Milwaukee hotline (1-888-947-4600) have been trained to mail out application materials to families and to assist families in navigating the eligibility determination system in Milwaukee County, which represents about one-third of the statewide Medicaid caseload. This hotline averages 500 calls per week.

  For a full description of our BadgerCare outreach strategies please see Section 3.4 of this report.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3

Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* Parents (Section 1115 Medicaid Waiver)	Other CHIP Program* ESI 1st made eligible for BadgerCare, then determine eligibility for ESI	Other CHIP Program* Family Coverage 1st made eligible for BadgerCare, then determine eligibility for Family Coverage
A. Comprehensive risk managed care organizations (MCOs)	Yes		Yes	No	No
Statewide?	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Mandatory enrollment?	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Number of MCOs	10		10		
B. Primary care case management (PCCM) program	N/A		N/A	N/A	N/A
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	N/A		N/A	N/A	N/A
D. Indemnity/FFS (specify services that are carved out to FFS, if applicable)	Chiro, dental, PNCC, targeted case management		Chiro, dental, PNCC, targeted case management		

* Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column."

Table 3.2.3					
Type of delivery system	**Medicaid CHIP Expansion Program**	**State-designed CHIP Program**	**Other CHIP Program* Parents (Section 1115 Medicaid Waiver)**	**Other CHIP Program* ESI 1st made eligible for BadgerCare, then determine eligibility for ESI**	**Other CHIP Program* Family Coverage 1st made eligible for BadgerCare, then determine eligibility for Family Coverage**
E. Other (specify)	Medicaid FFS, if while waiting for HMO enrollment or if no available HMOs or voluntary HMO situation.		Medicaid FFS, if while waiting for HMO enrollment or if no available HMOs or voluntary HMO situation.	Medicaid FFS, while waiting for enrollment in ESI. After enrolllment in ESI, MCO or FFS depending on availability of ESI plans.	Medicaid FFS, while waiting for enrollment in Family Coverage. After enrolllment in ESI, MCO or FFS depending on availability of Family C. plans.
F. Other (specify)					
G. Other (specify)					

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/ copayments, or other out-of-pocket expenses paid by the family.)

☐ No, skip to section 3.4

☒ Yes, check all that apply in Table 3.3.1

* Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column."

Table 3.3.1					
Type of cost-sharing	**Medicaid CHIP Expansion Program**	**State-designed CHIP Program**	**Other CHIP Program* Parents (Section 1115 Medicaid Waiver)**	**Other CHIP Program* ESI 1st made eligible for BadgerCare, then determine eligibility for ESI**	**Other CHIP Program* Family Coverage 1st made eligible for BadgerCare, then determine eligibility for Family Coverage**
Premiums	X		X	X	X
Enrollment fee					
Deductibles					
Coinsurance/ copayments**	X (Only for non-pregnant adults in Medicaid FFS)		X (Only for non-pregnant adults in Medicaid FFS)	X (Only for non-pregnant adults)	X (Only for non-pregnant adults)
Other (specify)				BadgerCare pays for all ESI coinsurance/ deductibles	BadgerCare pays for all Family Coverage coinsurance/ deductibles

Families with income above 150 percent but less than 200 percent of the FPL pay a monthly premium of 3 percent of family income. No family with income at or below 150 percent of the FPL pays a premium. Total family income has the same definition used for AFDC-related Medicaid.

The following services are exempted from copayments for BadgerCare non-pregnant adults in Medicaid FFS: nursing home services, emergency hospital and ambulance services, family planning services/supplies, SMV services, home health services, therapies over prior authorization limits, and other services.

For BadgerCare recipient enrolled in the Medicaid HMO program there are no enrollment fees, deductibles, coinsurance/copayments, or other types of fees.

* Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column."

** See Table 3.2.1 for detailed information.

3.3.2 If premiums are charged: What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

Premiums are collected on a monthly basis. Families who fail to pay the required premium are subject to a restrictive re-enrollment period of not more than six months, with exceptions provided for good cause. See attached spreadsheet for premium levels. Families have three payment options. They may use direct payment, Electronic Fund Transfer (EFT), or wage withholding. If wage withholding is chosen, the employer may use direct pay or EFT.

Example BadgerCare Premiums at premium income limit, applicant income limit & recipient income limit based on the $500 "band" model and 3% premium - Calendar Year 1999 FPL

group size	100% FPL	150% FPL	premium owed	185% FPL	premium owed	200% FPL	premium owed
	$670.83	$1,006.25	$30	$1,241.04	$30	$1,341.67	$30.00
2	$904.17	$1,356.25	$30	$1,672.71	$45	$1,808.33	$45.00
3	$1,137.50	$1,706.25	$45	$2,104.38	$60	$2,275.00	$60.00
4	$1,370.83	$2,056.25	$60	$2,536.04	$75	$2,741.67	$75.00
5	$1,604.17	$2,406.25	$60	$2,967.71	$75	$3,208.33	$90.00
6	$1,837.50	$2,756.25	$75	$3,399.38	$90	$3,675.00	$105.00
7	$2,070.83	$3,106.25	$90	$3,831.04	$105	$4,141.67	$120.00
8	$2,304.17	$3,456.25	$90	$4,262.71	$120	$4,608.33	$135.00
		Premium Income Limit		**Initial Income Limit**		**On-going Income Limit**	

3% of Total Family Income and $500 Range Premium Model

Total Family Income		Premium Amount
FROM	TO	
$1,000.00	$1,499.99	$30
$1,500.00	$1,999.99	$45
$2,000.00	$2,499.99	$60
$2,500.00	$2,999.99	$75
$3,000.00	$3,499.99	$90
$3,500.00	$3,999.99	$105
$4,000.00	$4,499.99	$120
$4,500.00	$4,999.99	$135

3.3.3 If premiums are charged: Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

☒ Employer
☒ Family
☒ Absent parent
☒ Private donations/sponsorship
☒ Other (specify) Any 3rd party may pay the premium

Anyone residing in the household may pay the premium.

3.3.4 If enrollment fee is charged: What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

No enrollment fee is charged.

3.3.5 If deductibles are charged: What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

No deductibles are charged.

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

BadgerCare implemented an extensive statewide outreach program. BadgerCare policies were and continue to be publicized using a variety of media and access points. Television and radio spots were used as well as extensive distribution of program brochures. Brochures were distributed to county agencies, health care facilities, employment agencies, employers, and eligibility determination sites. A toll-free telephone hotline is also available to respond to specific program and eligibility questions.

During the application process families are made aware of any premium and copayment obligations they may incur. BadgerCare applicants are also informed that they are required to report any changes in the family income that may affect the premium or copayment obligations of the family. BadgerCare recipients are sent a premium notice monthly unless they choose to pay their premiums by electronic funds transfer (EFT).

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

☐ Shoebox method (families save records documenting cumulative level of cost sharing)

☐ Health plan administration (health plans track cumulative level of cost sharing)

☐ Audit and reconciliation (State performs audit of utilization and cost sharing)

☒ Other (specify) A BadgerCare family cannot exceed the 5 percent cap even if they paid the maximum copayment for all the services that require a copayment. (See narrative below for further explanation.)

Narrative: BadgerCare recipients pay 3 percent of countable family income in premiums if their income is greater than 150 percent of the FPL. Below 150 percent they pay no premiums. In addition to the premium, some BadgerCare family members may have to pay a flat nominal copayment ranging from $.50 to $3 for some services. Most services that have a copayment have a maximum after which the recipient is not required to make further copayments. Only non-pregnant BadgerCare adults in Medicaid FFS pay copayments. Children and BadgerCare HMO enrollees are exempt from copayments.

In calendar year 1998, the average monthly Medicaid copayments charge to non-pregnant adults in FFS was $3.91. This represents 0.23 percent of monthly countable income for a family of three at 150 percent of the FPL and who are paying a premium of 3 percent. Thus, the total cost-sharing for this family would be 3.23 percent of family net income per month. Even if a family of three at the 150 percent FPL was paying four times the average copayments per month, or $15.64 per month, the total cost-sharing would only be 3.92 percent of family net income per month.

BadgerCare recipients who are bought into employer sponsored insurance are provided with wraparound coverage equal to the Wisconsin Medicaid program coverage. Private insurance deductibles, coinsurance, and copayments are billed by the provider and paid by BadgerCare as wraparound coverage. Their premium payment percentage and copayments are the same as other BadgerCare recipients.

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

None.

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

At the present time this has not been assessed. We have received very few complaints about the amount of the premium and have few people refuse BadgerCare because of the premium.

The DHFS plans to undertake a long term evaluation of the BadgerCare program. We plan to assess the effects of premiums on participation and the effects of cost sharing on utilization in this state evaluation.

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (T=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1										
Approach	**Medicaid CHIP Expansion**		**State-Designed CHIP Program**		**Other CHIP Program* Parents**		**Other CHIP Program* ESI**		**Other CHIP Program* Family Coverage**	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)					T = Yes	Rating (1-5)
Billboards										
Brochures/flyers	T	4			T	4	T	4	T	4
Direct mail by State/enrollment broker/ administrative contractor Medicaid card in Milwaukee contained information about BadgerCare and what number to call about the application process and outstation sites.	T	4			T	4	T	4	T	4
Education sessions Local social services and community organizations received training	T	4			T	4	T	4	T	4
Home visits by State/enrollment broker/ administrative contractor										
Hotline	T	4			T	4	T	4	T	4
Incentives for education/outreach staff										
Incentives for enrollees										
Incentives for insurance agents										
Non-traditional hours for application intake	T	3			T	3	T	3	T	3
Prime-time TV advertisements	T	5			T	5	T	5	T	5

* Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column."

Table 3.4.1										
Approach	**Medicaid CHIP Expansion**		**State-Designed CHIP Program**		**Other CHIP Program*** **Parents**		**Other CHIP Program*** **ESI**		**Other CHIP Program*** **Family Coverage**	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)					T = Yes	Rating (1-5)
Public access cable TV	T	3			T	3	T	3	T	3
Public transportation ads	T	4			T	4	T	4	T	4
Radio/newspaper/TV advertisement and PSAs	T	5			T	5	T	5	T	5
Signs/posters	T	4			T	4	T	4	T	4
State/broker initiated phone calls										
Other (specify) Brochures and posters in out languages, Spanish and Hmong sent to requesting agencies and distributed at health fairs, etc.	T	4			T	4	T	4	T	4
Other (specify) Targeted mailings to CBOs, FQHCs, Title 5 organizations, public health agencies, etc.	T	4			T	4	T	4	T	4
Other (specify) Program information, including enrollment data, linked to DHFS home page at www.dhfs.state.wi.us	T	4			T	4	T	4	T	4

* Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column."

3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (T=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2										
Setting	**Medicaid CHIP Expansion**		**State-Designed CHIP Program**		**Other CHIP Program* Parents**		**Other CHIP Program* ESI**		**Other CHIP Program* Family Coverage**	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)					T = Yes	Rating (1-5)
Battered women shelters	T	3			T	3	T	3	T	3
Community sponsored events	T	3			T	3	T	3	T	3
Beneficiary's home	T	3			T	3	T	3	T	3
Day care centers	T	4			T	4	T	4	T	4
Faith communities	T	3			T	3	T	3	T	3
Fast food restaurants	T	3			T	3	T	3	T	3
Grocery stores	T	3			T	3	T	3	T	3
Homeless shelters	T	3			T	3	T	3	T	3
Job training centers	T	3			T	3	T	3	T	3
Laundromats										
Libraries	T	3			T	3	T	3	T	3
Local/community health centers	T	4			T	4	T	4	T	4
Point of service/provider locations	T	4			T	4	T	4	T	4
Public meetings/health fairs	T	3			T	3	T	3	T	3
Public housing	T	3			T	3	T	3	T	3
Refugee resettlement programs	T	4			T	4	T	4	T	4

* Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column."

Table 3.4.2										
Setting	**Medicaid CHIP Expansion**		**State-Designed CHIP Program**		**Other CHIP Program* Parents**		**Other CHIP Program* ESI**		**Other CHIP Program* Family Coverage**	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)					T = Yes	Rating (1-5)
Schools/adult education sites	T	3			T	3	T	3	T	3
Senior centers	T	3			T	3	T	3	T	3
Social service agency	T	4			T	4	T	4	T	4
Workplace	T	3			T	3	T	3	T	3
Other (specify) Public Health Agency activities	T	4			T	4	T	4	T	4
Other (specify) WIC sites throughout the state	T	4			T	4	T	4	T	4

* Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column."

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

The methods and indicators used to assess outreach effectiveness are:

- **Caseload growth** – Since implementation in July 1999, the number of children in the Medicaid/BadgerCare program increased by 27,547 from June 1999 – February 2000.

- **Telephone data from customer 800 number calls** - The major sources of customers calls for BadgerCare information were:

  - 40 percent of the callers learned about the program from a TV ad
  - 26 percent from friends/relatives
  - 11 percent from a notice put on the previous month's Medicaid card
  - 8 percent from their caseworkers
  - 15 percent from a variety of sources

- **TV Data** - The ad reached over 90 percent of the target audience, adults ages 25 – 45. During the first three months of BadgerCare implementation the Milwaukee BadgerCare hotline logged over 8,000 calls. When asked how they heard about BadgerCare, about 34 percent responded that they had seen the ad on TV, the single largest response group.

- **Eligibility Outstationing** – To the extent that increased access resulted in improved customer service, eligibility outstationing contributed to BadgerCare enrollment growth. Applicants, local social service agencies, and provider sites overwhelmingly support outstationing as a meaningful improvement is service delivery for the application process.

  As of February 2000, Wisconsin had over 70 outstationing sites, and the number increases on a regular basis. Most have personal computer sites with dial-up, real-time capability to the CARES application processing system. In addition, all outstation sites have the capability to enter an application on CARES from an applicant's home.

Outstationing has proven to be very successful. For the period of June 1, 1999, through September 30, 1999, 3,288 Medicaid applications were taken at over 60 outstation sites. Outstationing has also generated significant inquiry activity. For the period of June 1, 1999, through September 30, 1999, 11,106 inquiries were made and of those contacts 4,288 application appointments were taken for some form of Medicaid.

- **Brochures/Posters** - More than 850,000 brochures and posters (copies also in Spanish and Hmong) have been distributed to a statewide mailing list that includes health care providers, public health departments, advocacy and other community organizations, economic support agencies, and school systems.

- **Training** – Concerted training efforts have resulted in a more knowledgeable eligibility staff and a better informed community resource network. Special Medicaid topics training sessions scored high in evaluations (4.3 out of 5) for 4,383 participants. Eligibility staff attendance for BadgerCare training totaled 1,368 participants who rated the training very high (4.1 out of 5, with 5 being the best). The HMO enrollment contractor, Automated Health Systems, Inc., trained 1,654 participants on Medicaid and BadgerCare basics. The sessions were conducted around the state and included a wide variety of agencies: Public health agencies, WIC agencies, school staff, pre-school staff, child care agencies, health care providers, HMOs, utility company staff, legal service agencies, insurance agencies, dental providers, Hmong agencies, Spanish agencies, food pantries, homeless shelters, employment and training agencies, elderly agencies, tribal health agencies, adoption agencies, federal agencies (including HCFA staff), and members of the faith community.

- **Public health** – The major work efforts of public health agencies were:

  - ***BadgerCare "OBRA Teen" Campaign.*** The Division of Public Health served as the state's lead agency in news media promotion of the April 1st start for extending BadgerCare to low-income teens. The DPH crafted a news release used by 11 newspapers statewide, with readerships of about 92,000. As of November, the enrollment category had exceeded 4,000.

  - ***Healthy Start Outreach.*** Outreach for Healthy Start, a marketing name for Medicaid coverage of certain pregnant women and children, reached all-time high enrollments for five consecutive months during the outreach funding period. Enrollment has risen by nearly 10 percent in 1999 and now exceeds 88,000. More than 412,000 Healthy Start brochures were distributed during the grant period.

- ***"Back to School" Initiative:*** Promoting BadgerCare and Medicaid among Wisconsin's nearly 1 million school children, DPH staff pursued promising strategies favored by outreach advocates nationwide. Back-to-school newspaper articles about the "subsidized lunch link" in the Milwaukee *Journal-Sentinel* and the Kenosha *News* generated more than 260 calls about the program. In Kenosha alone, a total of 17 families whose calls were generated by the article subsequently applied and received BadgerCare.

- *Medicaid Outreach Funds Targeted to Immunization Activities.* The Immunization Program outreach funds were used by local health departments for education and outreach activities to educate and refer families for Medicaid eligibility.

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

- Wisconsin completed a demonstration project in 1999 to determine the effectiveness of outreach to the Hispanic, Hmong and Russian communities in the southeastern part of the state, which includes Waukesha, Milwaukee, Racine, and Kenosha Counties. The Latino Health Organization was the contractor for the project, which has demonstrated a need for multi-lingual materials and translation services for Hispanic and Hmong populations.

- As previously described, our Medicaid and BadgerCare brochures and posters are in Spanish and Hmong versions, and are distributed at locations and to organizations relevant to those communities.

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

- Outreach efforts for Medicaid during 1997 – 98 stabilized the caseload at about 395,000 recipients. These activities included a TV spot, brochures, training, and public health agency outreach. Although the caseload did not increase, it did not decline further.

- These activities laid the foundation of successful implementation of BadgerCare, which allowed for a significant caseload increase.

- Aggressive outreach was coupled with the waiver program which enabled the BadgerCare and Medicaid population to grow. The combination of policy changes with aggressive outreach seems to be the most effective way of increasing the caseload during the past six months.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, othe r health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5**

Type of coordination	Medicaid*	Maternal and child health (WIC)	Other (specify) Birth to 3 Program	Other (specify) Public Health and Community Based Health Organizations	Other (specify) Milwaukee Child Welfare Agency	Other (specify) Medicaid FFS Programs: School Based Services, Prenatal Care Coordination Agencies, Targeted Case Management Agencies/Child Welfare Agencies
Administration		Medicaid HMO required to have an Advocate to coordinate with other health/social agencies.	Medicaid HMO required to have an Advocate to coordinate with other health/social agencies.	Medicaid HMO required to have an Advocate to coordinate with other health/social agencies.	Medicaid HMO required to have an Advocate to coordinate with other health/social agencies.	Medicaid HMO required to have an Advocate to coordinate with other health/ social agencies.

* Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

** This table applies to our CHIP program and the parents funded by Title XIX under our Section 1115 Demonstration Waiver. The ESI program and the Family Coverage program do not have the linkages with the other health programs/social services programs described above.

*Table 3.5***						
Type of coordination	**Medicaid***	**Maternal and child health (WIC)**	**Other (specify) Birth to 3 Program**	**Other (specify) Public Health and Community Based Health Organizations**	**Other (specify) Milwaukee Child Welfare Agency**	**Other (specify) Medicaid FFS Programs: School Based Services, Prenatal Care Coordination Agencies, Targeted Case Management Agencies/Child Welfare Agencies**
Outreach		Provided funding to public health agencies to coordinate T19/T21 referrals & outreach as part of MCH and WIC activities				
Eligibility determination						
Service delivery		Medicaid HMOs are required to make systematic referrals of eligible women, infants, children/give relevant information to the WIC program for their CHIP enrollees.	Medicaid HMOs are required to designate a B-3 contact person, make referrals to B-3 agencies, perform B-3 assessments, work with B-3 agency case manager to provide medically necessary services in the Individual Family Service Plan.	Medicaid HMOs are encouraged to coordinate with, contract with, and/or make referrals to local public health agency programs and local community based health organization programs: program coordination, health education, inspections,	Medicaid HMOs are required to coordinate (sign MOUs) with Milwaukee Child Welfare Agency to provide Medicaid covered mental health & substance abuse services to clients of this agency; work collaborativel y with agency	Medicaid HMOs are required to sign MOUs with these Medicaid specialized programs to coordinate services, make referrals, collaborate on case plans, etc.

* Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

** This table applies to our CHIP program and the parents funded by Title XIX under our Section 1115 Demonstration Waiver. The ESI program and the Family Coverage program do not have the linkages with the other health programs/social services programs described above.

*Table 3.5***						
Type of coordination	**Medicaid***	**Maternal and child health (WIC)**	**Other (specify) Birth to 3 Program**	**Other (specify) Public Health and Community Based Health Organizations**	**Other (specify) Milwaukee Child Welfare Agency**	**Other (specify) Medicaid FFS Programs: School Based Services, Prenatal Care Coordination Agencies, Targeted Case Management Agencies/Child Welfare Agencies**
				etc.	on developing and monitoring case plan and case plan progress.	
Procurement						
Contracting						
Data collection		Medicaid HMOs submit relevant medical data to WIC agencies on a WIC Referral Form.	Medicaid HMOs submit evaluation/assessment data to B-3 agency, shares diagnosis and treatment information with B-3 agency.		Medicaid HMOs submit referrals to agencies, receive information on case plan progress from agencies, share diagnosis/ treatment information.	Medicaid HMOs submit referrals to agencies, receive information on case plan progress from agencies, share diagnosis/treatment information.
Quality assurance						
Other (specify)						
Other (specify)						

* Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

** This table applies to our CHIP program and the parents funded by Title XIX under our Section 1115 Demonstration Waiver. The ESI program and the Family Coverage program do not have the linkages with the other health programs/social services programs described above.

* Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

Eligibility Determination Process: BadgerCare Policies to Prevent Crowd-Out of Private Insurance

The Department of Health and Family Services (DHFS) has implemented several policies to prevent crowd-out of private insurance.

1. Individuals are not eligible for BadgerCare if:

   - Currently covered or have been covered in the last three calendar months prior to the month of application by an individual or family health insurance policy, regardless of the amount of an employer's share of the premium, and,

   - The health insurance policy is not an accident or disability, liability, supplemental liability, automotive medical payment or liability, workers' compensation, credit-only, or other insurance plan that covers only on-site medical clinic, long-term care, nursing home care, home health care, community-based care, dental, vision, or pharmacy (drug card) plan.

   - An individual is not considered covered if the individual lost coverage in the last three months for any of the reasons listed below:

     - Loss of employment due to factors other than voluntary termination

     - Change to a new employer that does not offer coverage

     - Discontinuation of health benefits to all employees by the applicant's employer

     - End of COBRA Continuation

   - Individuals who are self-employed, including farmers, are considered covered by employer-offered group health plans, if:

** This table applies to our CHIP program and the parents funded by Title XIX under our Section 1115 Demonstration Waiver. The ESI program and the Family Coverage program do not have the linkages with the other health programs/social services programs described above.

- The individual purchased a plan that covered his/her family, or

- The business operated is incorporated and the individual is an employee of the corporation

2. Applicants with current access, or access in the 18 months prior to enrollment, to employer-provided family health insurance where the employers pay at least 80 percent of the cost of family coverage are not eligible for BadgerCare.

3. The State purchases employer-sponsored health insurance for families according to the following requirements of the Health Insurance Premium Payment Program (HIPP):

   - The family was not covered by an employer-sponsored health plan in the previous six months

   - The employer pays between 60 and 80 percent of the cost of the monthly premium for the health plan

   - It is cost-effective to buy an employer plan, including wraparound (BadgerCare FFS) coverage up to the BadgerCare benefit levels

Post-Eligibility Insurance Information and Verification: BadgerCare Policies to Prevent Crowd-Out of Private Insurance

The State performs research to determine if a BadgerCare family should be enrolled in the HIPP or if a family member has access to a family group health plan where the employer pays 80 percent or more of the premium. While this research is occurring, the BadgerCare family will be eligible for BadgerCare services.

1. State research on information on current or previous health insurance gathered on application.

   - When family member applies for BadgerCare at county, tribal, or W-2 agencies (welfare to work), he or she is asked if any family members are employed and if those employers offer a health plan or if any member of his/her household has health insurance or has been covered by health insurance in the last three months.

   - If the family is found eligible for BadgerCare, and any family members are employed, the State will send a HIPP Employer Verification of Insurance Coverage (EVIC) form to the employer(s) to gather information about the type of health plan offered, the cost of the plan, and the employer share of the premium.

   - If a family member is determined to have access to a family plan in which the employer pays 80 percent or more of the premium or has access to a state employee's group health plan, the fiscal agent investigates to determine which family members would be covered by the plan.

   - If the family member reports that he or she do not have access to employer-sponsored insurance, or is not employed, the family begins the BadgerCare managed care enrollment process while receiving FFS coverage, in pending status, while the fiscal agent verification or follow-up with any employer occurs.

2. Records Match

   - When eligibility for BadgerCare is confirmed on CARES, the CARES/MMIS Interface Subsystem sends the individual's eligibility information to the fiscal agent.

   - The fiscal agent performs monthly and semi-annual data matches of all current Medicaid and BadgerCare recipients, using health care coverage information submitted by local and national insurance carriers that sell or issue health care policies to residents

of Wisconsin. Any resulting recipient match automatically updates insurance coverage information in his or her record, and relays that information to CARES via the data interface subsystem.

- If CARES receives information regarding private health insurance for a BadgerCare recipient, an alert is generated for the eligibility worker. The worker will review the insurance information to ensure that the information is correct. The case will be scheduled for selection in the next "adverse action" date. When the system re-runs the BadgerCare eligibility file, BadgerCare coverage will be terminated for a recipient with other coverage.

- If the fiscal agent research determines that a BadgerCare recipient family member has access to a family plan with which the employer pays 80 percent or more of the premium or has access to a state employee's group health plan, the information is sent to CARES via the CARES/MMIS Interface Subsystem and the persons who would be covered by the group health plan or state employee's plan will lose BadgerCare eligibility.

Benefit Package Design and Cost Sharing: BadgerCare Policies to Prevent Crowd-Out of Private Insurance

BadgerCare eligibility is limited to families whose income does not exceed 185 percent of the FPL. Once eligible, families may remain in BadgerCare until their income exceeds 200 percent of the FPL. Employer-subsidized health insurance is not common among families with income at or below these amounts.

- BadgerCare benefits are the same as Medicaid. FFS wraparound coverage may be extended to individuals enrolled in certain employer-sponsored health plans under the HIPP.

- Participating families with incomes above 150 percent of the FPL may be assessed a premium cost share of 3 percent of their monthly net family income.

- Participating families found eligible for HIPP are required to enroll in their employer-sponsored health plan or lose eligibility for BadgerCare.

- Participating families lose eligibility for non-payment of HIPP premiums without good cause and must wait six months before they may be re-enrolled in BadgerCare.

Employer Education: BadgerCare Policies to Prevent Crowd-Out of Private Insurance

- The BadgerCare marketing/public information campaign stresses the importance of employer-sponsored health insurance. Employers with low-income workers who may be eligible for BadgerCare are directed to the BadgerCare Internet address or mailed printed material describing program eligibility requirements.

Additional Measures to Control Crowd-Out of Private Insurance

1. Wisconsin Statutes chapter 632.745(5) requires employers that offer health insurance to offer the same health care plan to all of their employees. This policy was designed to prevent employers from offering a health insurance plan to only the most highly compensated employees.

2. A provision of 1999 Wisconsin Act 9 authorizes the design and operation of a private employer health care coverage program. The legislation, in part, provides infrastructure to create a new risk pool for small business employers to purchase group health insurance for their employees. Small businesses are more likely to be affected by small group rating practices, including premium increases, and often lack the stability and capacity to administer employee benefit programs.

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

A. Procedures and Protocol: Monitoring Crowd-Out

1. System edits and protocols in CARES and MMIS monitor and prevent BadgerCare enrollment of families with current HIPAA-creditable coverage or such coverage within the past three months, or current access, or within past 18 months, to employer-sponsored insurance where the employer pays 80 percent or more of the premium. The following data points are to be monitored:

   - The number of BadgerCare applications denied eligibility due to current health insurance coverage or coverage in the previous three months

   - The number of BadgerCare applications given a pending status because of missing health insurance information

   - The number of BadgerCare recipients terminated due to other health insurance indicators found as a result in of the CARES and MMIS interface

   - The total number of BadgerCare applications and total number of approved BadgerCare applications

2. DHFS will use the Family Health Survey (FHS) to project the number of children in households under 200 percent of the FPL who are insured through employer coverage. This number will be reported as a percentage of the total number of children under 200 percent of FPL and compared to projections between baseline and measurement years.

3. The Medicaid fiscal agent conducts continuous tracking of information provided by applicants and eligibility workers in the course of BadgerCare eligibility determination. Anecdotal reports that may suggest the occurrence of crowd-out of private insurance are compiled, reported and may be subject to follow-up by the fiscal agent and DHFS.

B. What we have found to date about the possibility of crowd-out

1. BadgerCare is reaching those families who are most likely to be uninsured. Over 90 percent of families enrolled have incomes below 150 percent of the FPL. Based on the survey of employers that Wisconsin does to verify BadgerCare employees current insurance status, 65 percent of employers surveyed indicate that the employee has no access to family coverage.

2. The DHFS plans to perform a detailed evaluation of BadgerCare to assess the impact of BadgerCare policies on crowd-out. This evaluation is part of our Section 1115 Demonstration Waiver for BadgerCare.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

Table 4.1.1 in NASHP Framework for State Evaluations - CHIP Medicaid Expansion for Children - BadgerCare

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Year end enrollees as percentage of unduplicated enrollees per year	
	FFY 1998[a]	FFY 1999[a]	FFY 1998[a]	FFY 1999[a]	FFY 1998[a]	FFY 1999[a]
All Children	0	12,949	-	2.5	-	86.3%
Age						
Under 1	0	20	-	1.5	-	70.0%
1-5	0	231	-	1.5	-	74.5%
6-12	0	4,534	-	2.0	-	95.3%
13-18	0	8,164	-	2.9	-	81.7%

[a] Wisconsin implemented phase 1 of BadgerCare in April 1, 1999, and began reporting enrollment data for its M-SCHIP program in Quarter three, FFY 1999; therefore, data for FFY 1999 are only partial year. There is no data for FFY 98.

Table 4.1.1 in NASHP Framework for State Evaluations - CHIP Medicaid Expansion for Children - BadgerCare						
Characteristics	**Number of children ever enrolled**		**Average number of months of enrollment**		**Year end enrollees as percentage of unduplicated enrollees per year**	
	FFY 1998[a]	**FFY 1999[a]**	**FFY 1998[a]**	**FFY 1999[a]**	**FFY 1998[a]**	**FFY 1999[a]**
Countable Income Level[*]						
At or below 150% FPL	0	11,704	-	2.6	-	85.3%
Above 150% FPL	0	1,245	-	2.1	-	96.0%
Age and Income Under 1						
At or below 150% FPL	0	18	-	1.4	-	72.2%
Above 150% FPL	0	2	-	2.5	-	50.0%
1-5						
At or below 150% FPL	0	184	-	1.5	-	73.9%
Above 150% FPL	0	47	-	1.5	-	76.6%
6 – 12						
At or below 150% FPL	0	3,820	-	1.9	-	95.0%
Above 150% FPL	0	714	-	2.1	-	96.5%
13-18						
At or below 150% FPL	0	7,682	-	2.9	-	80.8%
Above 150% FPL	0	482	-	2.2	-	97.3%
Type of plan						
FFS	0	7,163	-	2.2	-	88.8%
Managed care	0	5,786	-	3.0	-	83.2%
PCCM	0	0	-	-	-	-

[*] Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150 percent FPL. See the HCFA Quarterly Report instructions for further details.

[a] Wisconsin implemented phase 1 of BadgerCare in April 1, 1999, and began reporting enrollment data for its M-SCHIP program in Quarter three, FFY 1999; therefore, data for FFY 1999 are only partial year. There is no data for FFY 98.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

Table 4.1.1 in NASHP Framework for State Evaluations – Section 1115 Demonstration Waiver for Parents – BadgerCare						
Characteristics	**Number of adults ever enrolled**		**Average number of months of enrollment**		**Year end enrollees as percentage of unduplicated enrollees per year**	
	FFY 1998[a]	**FFY 1999[a]**	**FFY 1998[a]**	**FFY 1999[a]**	**FFY 1998[a]**	**FFY 1999[a]**
All Adults	0	17,215	-	2.1	-	99.8%
Countable Income Level[*]						
At or below 150% FPL	0	15,550	-	2.1	-	99.7%
Above 150% FPL	0	1,665	-	2.1	-	100%
Type of plan						
FFS	0	12,513	-	2.0	-	99.8%
Managed care	0	4,702	-	2.5	-	99.7%
PCCM	0	0	-	-	-	-

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

NOTE: NO PERSONS WERE ELIGIBLE FOR ESI/FAMILY COVERAGE IN FFY 99

Supplemental data for CHIP Medicaid Expansion for Children and Section 1115 BadgerCare Waiver for Parents - As of February 2000[*]

BADGERCARE ENROLLMENT THROUGH FEBRUARY 2000	Parents	Children	Total
Uninsured Under 200% FPL (Based on 1997 & 1998 Wisconsin Family Health Survey)	90,000	54,000	144,000
Enrolled in BadgerCare	38,188	15,108	53,296

[*] Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150 percent FPL. See the HCFA Quarterly Report instructions for further details.

[a] Wisconsin implemented phase 1 of BadgerCare in April 1, 1999, and began reporting enrollment data for its M-SCHIP program in Quarter three, FFY 1999; therefore, data for FFY 1999 are only partial year. There is no data for FFY 98.

[*] No persons enrolled in ESI/Family Coverage through February 2000.

Low Income Teenagers (OBRA Expansion)		4,186	4,186
Total BadgerCare	38,188	19,294	57,482
At or below 150% FPL	34,354	16,419	50,773
Above 150% FPL	3,834	2,875	6,709
Increased Medicaid Healthy Start Children due to BadgerCare Outreach and BadgerCare/Medicaid Coordination		8,253	8,253
Total BadgerCare and Medicaid Increase	38,188	27,547	65,735
As percentage of uninsured under 200% FPL	42.4%	51%	45.6%

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

Insufficient data exists to establish this number at this time. We will include this in the next report. Data will be obtained from the CARES eligibility system and the MMIS.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

There are a number of "State only" and other publicly funded health programs in Wisconsin.

WisconCare is a small program in 17 counties with high unemployment rates that provides a limited scope of outpatient primary care and inpatient maternity/ delivery services. Eligibility is based on unemployment or employment of less than 25 hours per week with income less than 150 percent FPL. Persons are not eligible if they are enrolled in Medicaid, BadgerCare, or private insurance.

The target population for children is now covered by BadgerCare. The BadgerCare eligibility requirements are more liberal (185 percent FPL). BadgerCare seems to have enrolled most of the children previously in WisconCare. The most recent data we have is for February 2000, where only 22 children 0 - 20 remain in the program.

General Relief medical care is a state funded program provided by some counties at their discretion. Primary medical/dental care is provided. Eligibility criteria are set by participating counties. Individuals cannot be eligible for Medicaid/BadgerCare. Approximately 22,000 persons are enrolled. has enrolled some of the children previously in general relief.

HIRSP (Health Insurance Risk Sharing Program) is a state funded program to provide health insurance to persons that cannot get private health insurance or are not eligible for Medicaid or BadgerCare. Recipients in HIRSP are required to pay a fairly high premium. There were 7,768 enrolled in HIRSP in November 1999. Only about 250 children are currently enrolled in HIRSP; given the high premium required, these children are likely from higher income families.

Community Service Programs, funded by State and County expenditures and matched with federal funds from various block grant programs, where possible, provide a number of health benefits to Wisconsin residents. The services/ programs are administered at the local level by county departments of social services. The key health services provided in these programs are mental health services and alcohol and other drug abuse services.

1999 data on children served with these funds are not available. In 1998, the following data is available on non-Medicaid Wisconsin children (0 - 21) served by community service programs:

Mental Health Services:	11,475
Alcohol/Other Drug Abuse Services:	6,407

There is no hard data on the percentage of the above children who have private health insurance, but anecdotal evidence indicates that it would be very small.

Maternal and Child Health (MCH) Title V programs provide a variety of primary health services to children in Wisconsin under a federal block grant program. The most recent data we have is for calendar year 1997. The number of children served through age 21 with no Medicaid or private insurance was 25,998.

Women, Infants, Children (WIC) programs are federally-funded state projects that provide health screening and assessment services to children in addition to food supplies and counseling services. As of September, 1999, 8,357 uninsured children aged 0 - 5 are enrolled in WIC projects. 98.4 percent of these children served are under 185 percent FPL.

Uncompensated Inpatient Hospital Care. Most Wisconsin hospitals provide some uncompensated care. In addition, there are approximately 13 Hill-Burton Hospitals. In calendar year 1998 there were 4,110 inpatient hospital visits for children 0 - 18 in Wisconsin hospitals that were identified as "self-pay" payors. The vast majority of these visits were written off by the hospitals as uncompensated care.

Public Health Immunizations. The Division of Public Health (DPH) and local public health agencies distribute free vaccines through the Vaccines for Children (VFC) program to public and private providers. Local public health agencies also provide free immunizations throughout the state in all 72 counties. The DPH collects information on immunizations provided through the local public health agencies and private providers. In calendar year 1999, 63,475 uninsured children from 0 - 18 received immunizations. In addition, for the same time period, 130,533 underinsured children from 0 - 18 received immunizations. Underinsured means that the children's insurance did not cover the cost for providing immunizations.

Birth to 3 Program. This is an entitlement program established by the Federal Individual with Disabilities Education Act (IDEA). The goal is to provide early intervention services to children from birth up to the age of 3 who have developmental disabilities or delays. The program is funded by Federal, state, and local funds. Federal IDEA, Part C funds are the payor of last resort. There are local birth to 3 programs in each county in Wisconsin.

In calendar year 1999, 4,629 children received medical care through the birth to 3 program. 3.6 percent of those children were uninsured, or 167 children. Approximately 70 percent of the birth to 3 caseload are in Medicaid and services are coordinated between Medicaid HMOs and local birth to 3 agencies.

4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

As can be seen from Table 4.1.1, 1,770 children disenrolled from BadgerCare in FFY 99. This was a disenrollment rate of 13.7 percent for the period April 1999 – September 1999, since the acceleration of OBRA children began April 1, 1999.

Also in Table 4.1.1, 40 adults disenrolled from BadgerCare in FFY 99. This was a disenrollment rate of .2 percent for the period July 1999 – September 1999, since the full BadgerCare program began July 1, 1999.

These disenrollment rates were lower than Medicaid disenrollment rates, which are more sensitive to minor income changes, changes of age, changes in assets, and loss of pregnancy status.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

BadgerCare began on April 1, 1999 with the acceleration of the phase-in of OBRA children, ages 16 through 18 years old. The program to include all children under age 19 and parents of children under age 19, began on July 1, 1999. Since BadgerCare has a 12-month redetermination period, as of March 31, 2000, no one had lost eligibility due to missing a redetermination.

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

See the table below for the reasons and frequency that individuals and families (cases) lost BadgerCare eligibility. The source of this data is the CARES databases, which we queried using a special utility program for anyone from April 1, 1999, through February 29, 2000, who was terminated from the BadgerCare program.

As you can see many of the individuals who 'lost' BadgerCare eligibility (9,853 - reason code 32), were found to be eligible for a Medicaid subprogram.

Table 4.2.3 - Total for CHIP Medicaid Expansion, Section 1115 Waiver for Adults, ESI, and Family Coverage *4/1/99 - 2/29/00*			
Reason Code for Discontin-uation of Coverage	**Description**	**Individuals**	**Percentage of Total for Individuals**
5	Failed to cooperate with the Child Support agency.	261	2.00%
14	Income exceeds the net income limit.	0	
19	Is already receiving this assistance.	9	.06%
28	No person meets program requirements.	1	
30	There are fewer people eligible for this program.	0	
31	Due to death of the individual.	18	.14%
32	Individual in the same case but different category.	9853	74.05%
39	Is neither a citizen nor a qualifying alien.	13	.10%
60	Failed to cooperate with Third Party Liability requirements.	3	
66	Unearned income increased.	0	
68	Already receives MA through SSI.	106	.80%
80	Declaration of citizenship not completed.	3	
84	Is not in a qualifying living arrangement.	245	1.84%
90	Not cooperating with Medical Support Liability requirements.	2	
93	Refuses to give or get a Social Security Number.	6	
112	Did not verify information.	7	
113	Failed to provide information.	2	
114	Primary person requested to exclude this person.	85	.64%
115	Does not have a qualifying relationship to Primary Person.	11	.08%
116	This person does not meet individual program requirements.	1	
132	Income from self-employment has increased.	0	

Table 4.2.3 - Total for CHIP Medicaid Expansion, Section 1115 Waiver for Adults, ESI, and Family Coverage *4/1/99 - 2/29/00*			
Reason Code for Discontin-uation of Coverage	**Description**	**Individuals**	**Percentage of Total for Individuals**
141	Does not meet program requirements.	2679	20.14%
144	Application denied. Individual must reapply.	0	
236	S/he does not reside in Wisconsin.	0	
237	S/he does not intend to reside in Wisconsin	0	
279	Is not a parent or stepparent of a child under the age of 19.	0	
280	Is covered by an insurance plan.	0	
281	Had health plan coverage in the last 3 months.	0	
283	Is not cooperating with the premium payment program (HIPP).	0	
284	Access to health plan-employer pays 80% or more of premium.	0	
287	Can't receive BadgerCare until restrictive re-enrollment ends.	0	
290	Chose to meet a MA deductible rather than BadgerCare.	0	
295	You must request Medicaid to receive BadgerCare.	0	
296	You have not paid your premium.	0	
TOTALS		**13,305**	

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

There is no reason that a child would disenroll, if s/he were not still eligible.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 0
FFY 1999 $5,993,615 (Total Computable)

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Table 4.3.1

	T-21 Kids on HCFA 64-21U FFY 99*		T-19 Parents on HCFA 64-21U FFY 99*		Total FFY 99*	
	Total Computable	Federal Share	Total Computable	Federal Share	Total Computable	Federal Share
Premiums to 150	741,557.00	527,989.00	1,341,869.00	789,690.00	2,083,426.00	1,317,679.00
Prem. 150+	1,491,883.00	1,062,221.00	117,731.00	69,285.00	1,609,614.00	1,131,506.00
Cost sharing offset	(3,559.00)	(2,534.00)	(4,871.00)	(2,867.00)	(8,430.00)	(5,401.00)
Net Premiums	2,229,881.00	1,587,676.00	1,454,729.00	856,108.00	3,684,610.00	2,443,784.00
Inpatient Hospital	167,246.00	119,078.00	501,929.00	295,385.00	669,175.00	414,463.00
IP-DSH	474.00	337.00	-	-	474.00	337.00
Total Inpatient	167,720.00	119,415.00	501,929.00	295,385.00	669,649.00	414,800.00
IP-MH	1,668.00	1,188.00	-	-	1,668.00	1,188.00
IP-MH-DSH	-	-	-	-	-	-
Total IP-MH	1,668.00	1,188.00	-	-	1,668.00	1,188.00
Nursing Care	434.00	309.00	72.00	43.00	506.00	352.00
Phys & Surg	47,554.00	33,858.00	59,467.00	34,997.00	107,021.00	68,855.00
Outpatient Hospital	90,119.00	64,164.00	186,153.00	109,550.00	276,272.00	173,714.00
OP - MH	5,346.00	3,806.00	-	-	5,346.00	3,806.00

* There were no BadgerCare expenditures claimed in FFY 98, nor were any ESI/Family Coverage enrolled in FFY 99.

Table 4.3.1						
	T-21 Kids on HCFA 64-21U FFY 99*		**T-19 Parents on HCFA 64-21U FFY 99***		**Total FFY 99***	
	Total Computable	**Federal Share**	**Total Computable**	**Federal Share**	**Total Computable**	**Federal Share**
Drugs	101,845.00	72,514.00	444,559.00	261,621.00	564,404.00	334,135.00
Rebates Nat'l	-	-	-	-	-	-
Rebates State	-	-	-	-	-	-
Dental	66,576.00	47,402.00	53,161.00	31,286.00	119,737.00	78,688.00
Vision	15,815.00	11,261.00	31,862.00	18,751.00	47,677.00	30,012.00
Other Practitioners	20,631.00	14,689.00	32,589.00	19,178.00	53,220.00	33,867.00
Clinics	92,612.00	65,940.00	180,124.00	106,005.00	272,736.00	171,945.00
Therapy	747.00	532.00	155.00	91.00	902.00	623.00
Lab-Xray	34,377.00	24,477.00	86,039.00	50,634.00	120,416.00	75,111.00
DME/DMS	2,525.00	1,797.00	3,862.00	2,272.00	6,387.00	4,069.00
Family Planning	5,487.00	4,938.00	22,850.00	20,566.00	28,337.00	25,504.00
Abortion	-	-	-	-	-	-
HC Screening	8,801.00	6,266.00	277.00	163.00	9,078.00	6,429.00
Home Health	408.00	290.00	6,962.00	4,097.00	7,370.00	4,387.00
Medicare	-	-	6,599.00	3,884.00	6,599.00	3,884.00
HCBS	-	-	-	-	-	-
Hospice	-	-	-	-	-	-
Transportation	7,895.00	5,622.00	6,026.00	3,547.00	13,921.00	9,169.00
Case Management	3,806.00	2,709.00	-	-	3,806.00	2,709.00
Other Services	5,536.00	3,941.00	7,407.00	4,358.00	12,943.00	8,299.00
Total	2,909,783.00	2,072,794.00	3,084,822.00	1,822,536.00	5,994,605.00	3,895,330.00
Collections	(990.00)	(705.00)	-	-	(990.00)	(705.00)
Total	2,908,793.00	2,072,089.00	3,084,822.00	1,822,536.00	5,993,615.00	3,894,625.00

* There were no BadgerCare expenditures claimed in FFY 98, nor were any ESI/Family Coverage enrolled in FFY 99.

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap? 0[1]

[1] Wisconsin intends to claim administrative funds up to the 10 percent cap. BadgerCare is too recently implemented for Title XXI funds to have been claimed for administration. We intend to claim the following total computable share costs for administration with Title XXI funds @ the 10 percent cap limit retroactive for FFY 99 and through FFY 2002:

FFY 1999: $ 323,199
FFY 2000: $ 5,420,258
FFY 2001: $15,567,022
FFY 2002: $16,758,639

What role did the 10 percent cap have in program design? _____

Table 4.3.2**

Type of expenditure	Medicaid Chip Expansion Program No Admin. Claimed under Title 21		State-designed CHIP Program		Other CHIP Program* Adults Admin. costs not separated out from waiver for Title 19		Other CHIP Program* ESI No data. No one enrolled as of 9/30/99		Other CHIP Program* Family Coverage	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share										
Outreach										
Administration										
Other										
Federal share										
Outreach										
Administration										
Other										

* Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column."

** No administration costs for Title XXI claimed yet for FFY 99. We plan to retroactively claim $323,199 total computable share costs for FFY 99, for a federal share of $230,118.

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

- ☒ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations (such as United Way, sponsorship)
- ☒ Other (specify) Recipient premium collections

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in FFS, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

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* Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column."

** No administration costs for Title XXI claimed yet for FFY 99. We plan to retroactively claim $323,199 total computable share costs for FFY 99, for a federal share of $230,118.

Table 4.4.1					
			Other CHIP Programs		
Approaches to monitoring access	MA CHIP expansion	State designed CHIP	Section 1115 Waiver Adults	ESI	Family Coverage
Appointment audits	MCO	NA	MCO	NA	NA
PCP/enrollee ratios	MCO	NA	MCO	NA	NA
Time/distance standards	MCO	NA	MCO	NA	NA
Urgent/routine care access standards	MCO	NA	MCO	NA	NA
Network adequacy reviews	MCO	NA	MCO	NA	NA
Complaint/grievance & disenrollment reviews	MCO	NA	MCO	NA	NA
Case file reviews	MCO/FFS	NA	MCO/FFS	NA	NA
Beneficiary surveys	MCO	NA	MCO	NA	NA
Utilization analysis	MCO/FFS	NA	MCO/FFS	NA	NA

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2					
			Other CHIP Programs		
Type of utilization data	MA CHIP expansion	State designed CHIP	Adults	ESI	Family Coverage
Require submission of raw encounter data by MCO	Yes	NA	Yes	NA	NA
Require submission of HEDIS® data by MCO	No*	NA	No*	NA	NA
Other: State-specified data	Yes	NA	Yes	NA	NA

* The Wisconsin Medicaid/BadgerCare HMO Program uses utilization indicators which are similar to commercial HEDIS® data. Many of our indicators use the same definitions for the indicator numerators as does commercial HEDIS®. The Targeted Performance Improvement Indicators use a different definition of the denominator than does commercial HEDIS®, to adjust for the lower continuity of eligibility in Medicaid/BadgerCare compared to commercial populations. Our other utilization indicators standardize the denominator to eligible years.

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

Insufficient data is available at this time for analysis on the state-specified measures. HMOs will be required to submit a separate Utilization/Survey Report for BadgerCare HMOs beginning CY 2000. The first 6 months submission for CY 2000 will be available for analysis in December 2000. HMOs will be required to submit complete monthly encounter data for all their enrollees beginning May 2000, retroactive to January 2000. Quarterly history data for BadgerCare enrollees for July - December 1999 will be available for analysis by October 1, 2000.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

HMOs will be required to submit a separate Utilization/Survey Report for BadgerCare HMOs beginning CY 2000. The first 6 months submission for CY 2000 will be available for analysis in December, 2000. HMOs will be required to submit complete monthly encounter data for all their enrollees beginning May 2000, retroactive to January 2000. Quarterly history data for BadgerCare enrollees for July - December 1999 will be available for analysis by October 1, 2000.

HMOs will be reporting for their BadgerCare enrollees on the full set of QAPI measures previously described in Section 1.3.

4.5 How are you measuring the quality of care received by CHIP enrollees?

What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

Table 4.5.1

Approaches to monitoring access	MA CHIP expansion	State designed CHIP	Other CHIP Programs		
			Section 1115 Waiver Adults	ESI	Family Coverage
Focused studies (performance improvement projects) See **Table 1.3** for specifications.	MCO	NA	MCO	NA	NA
Client satisfaction surveys	MCO	NA	MCO	NA	NA
Complaint/grievance reviews	MCO	NA	MCO	NA	NA
Sentinel event reviews	NA	NA	NA	NA	NA

Table 4.5.1					
			Other CHIP Programs		
Approaches to monitoring access	MA CHIP expansion	State designed CHIP	Section 1115 Waiver Adults	ESI	Family Coverage
Plan site visits	MCO	NA	MCO	NA	NA
Case file reviews	MCO/FFS	NA	MCO/FFS	NA	NA
Independent peer review	MCO/FFS	NA	MCO/FFS	NA	NA
HEDIS® measures	No*	NA	No*	NA	NA
Other: State-specified measures. See **Table 1.3** for specifications.	MCO	NA	MCO	NA	NA

* The Wisconsin Medicaid/BadgerCare HMO Program uses utilization indicators which are similar to commercial HEDIS® data. Many of our indicators use the same definitions for the indicator numerators as does commercial HEDIS®. The Targeted Performance Improvement Indicators use a different definition of the denominator than does commercial HEDIS®, to adjust for the lower continuity of eligibility in Medicaid/BadgerCare compared to commercial populations. Our other utilization indicators standardize the denominator to eligible years.

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

Insufficient data is available at this time for analysis on the state-specified measures. HMOs will be required to submit a separate Utilization/Survey Report for BadgerCare HMOs beginning CY 2000. The first 6 months submission for CY 2000 will be available for analysis in December 2000. HMOs will be required to submit complete monthly encounter data for all their enrollees beginning May 2000, retroactive to January 2000. Quarterly history data for BadgerCare enrollees for July - December 1999 will be available for analysis by October 1, 2000.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

HMOs will be required to submit a separate Utilization/Survey Report for BadgerCare HMOs beginning CY 2000. The first 6 months submission for CY 2000 will be available for analysis in December, 2000. HMOs will be required to submit complete monthly encounter data for all their enrollees beginning May 2000, retroactive to January 2000. Quarterly history data for BadgerCare enrollees for July - December 1999 will be available for analysis by October 1, 2000.

HMOs will be reporting for their BadgerCare enrollees on the full set of QAPI measures previously described in Section 1.3.

In addition, the full range of Medicaid HMO quality improvement activities will also apply to BadgerCare HMO enrollees. For more information, see Section 4.6 below.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

The full range of current and planned Medicaid HMO quality improvement activities will also apply to BadgerCare HMOs and BadgerCare HMO enrollees.

Appendix 1 contains materials that describe current and planned Wisconsin Medicaid HMO quality improvement activities. The materials listed include the following:

- Overview of the Key Elements of the Wisconsin Medicaid HMO Quality Assurance Performance Improvement (QAPI) Plan

- Calendar Year 1997 Wisconsin Medicaid HMO Comparison Report. Section 3 of this report provides an overview of our current quality improvement activities, which are applicable to calendar years 1998, 1999, 2000, and 2001.
- A Brochure describing 4 workshops to be held around the state in the Spring/ Summer of 2000 for HMOs and other interested parties described DHFS strategies/methodology for measurement of Wisconsin HMO quality of clinical care.

- A Brochure described a DHFS sponsored statewide conference on Improving HealthCheck performance in the Spring of 2000. Details of this conference are described below:

  Wisconsin Medicaid is sponsoring a statewide HealthCheck conference on April 11, 2000. The goal of this conference is to increase statewide participation and quality in HealthCheck screenings. This will be accomplished by networking with various community organizations and public/private agencies to effectively and efficiently serve the Medicaid/BadgerCare members under the age of 21.

Panel discussions will include:

- HealthCheck Special Project Grants
- A primary Care Perspective on Achieving the HealthCheck Goal
- Successful National HealthCheck Efforts
- Linking Community HealthCheck Services
- Focus Groups Results: Preventative Health Perspectives from Rural Wisconsin
- Successful Collaborative Efforts

Breakout Sessions will include:

- Provider Barriers to Performing HealthCheck Screenings
- Recipient Barriers in Obtaining HealthCheck Screenings
- Effective Rural Outreach
- Effective Urban Outreach
- Understanding Cultural Diversity as it Relates to HealthCheck Screenings

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

Lessons Learned/Best Practices

Eligibility Determination/Redetermination:

1. **Coordination with Medicaid eligibility determination and redetermination:** The essential factor in the successful implementation of BadgerCare eligibility determination/redetermination was to incorporate it into the current CARES system used for Medicaid determination/redetermination.

   Wisconsin Medicaid has an extensive statewide, automated, integrated eligibility determination system called Client Assistance for Reemployment and Economic Support (CARES). An eligibility worker collects family and financial data through an interactive interview prompted by CARES, which then determines eligibility by applying federal and state law for four programs (Medicaid, food stamps, child care and TANF) and generates the appropriate notices and benefits. Because the policy logic is built into the system, CARES prompts the worker to gather the correct data, and applies that data in a standardized and consistent way for each case, thereby assuring the integrity of the eligibility determination process.

   Families who want to receive Medicaid can apply at the county department of social or human services, at the tribal or W-2 agency or at outstation sites.

We designed BadgerCare to use this Medicaid eligibility determination and redetermination system because it was less confusing to customers, more efficient to administer, and to assure compliance with federal requirements.

We also knew in designing the BadgerCare program that there would be many families eligible for BadgerCare that would have some family members that were eligible for Medicaid. Recent data from March 2000 show that 55 percent of the current BadgerCare cases contain one or more family members who are eligible for Medicaid.

For these reasons, BadgerCare was built upon the structure that supports the Medicaid program, with county workers processing applications, using the CARES system for the interactive interview and eligibility determination. This minimized administrative costs, and integrated the program delivery to families, who may have some family members who qualify for Medicaid coverage and some who qualify under the BadgerCare expansion. This allows coordination between Medicaid and BadgerCare, with applicants tested for Medicaid eligibility prior to being tested for BadgerCare.

This design feature allowed Wisconsin to standardize eligibility policy between BadgerCare and Medicaid to the extent possible, and facilitates the development of new intake options that offer alternatives to working parents.

2. **Coordination with Food Stamps Eligibility Determination and Redetermination:** The integration of BadgerCare with CARES also allowed us to coordinate the BadgerCare and Food Stamps programs. Both programs serve the same low-income working population and it is essential that they operate in a uniform way to the maximum extent possible. This includes uniformity of processing requirements, frequency of redetermination, and treatment of income. To do otherwise is very confusing for customers and eligibility workers and adds administrative costs to federal, state, and local governments.

Enrollment:

The successful implementation of BadgerCare as both a CHIP initiative as well as a Medicaid enrollment initiative can be traced to the following outreach strategies. The specifics on each are listed above.

1. **Statewide capacity building.** This effort (laying the foundation for BadgerCare) was started two years before program implementation. This was accomplished through a series of general training efforts for community organizations about Medicaid and technical training sessions for income maintenance agencies. In addition, outreach grants to public

health agencies and advocate agencies increased collaboration at the local level, in particular in large urban areas such as Milwaukee, Kenosha, and Madison. These educational and collaborative efforts laid the groundwork for the outreach efforts needed for BadgerCare.

2. **Outstationing of eligibility staff and FQHC outstationing expansion.** Both outstationing efforts increased program access points for customers and expanded the DHFS customer service model.

3. **Program start-up funding.** Additional funding for local social service agencies before BadgerCare implementation allowed for effective local planning to deal with caseload increases.

4. **Training.** Similar training efforts for BadgerCare as were completed for Medicaid provided useful information for social service agencies for eligibility decisions and provided community groups the information to deliver effective outreach.

5. **Importance of name change.** The program name was changed from Medicaid to BadgerCare. This change sent a message to new applicants that health insurance for low income working families was no longer associated with welfare. This stigma was minimized in many household's understanding of the program. One family, at the end of the application process, inquired about also applying for life insurance. This illustrates that many families do not view BadgerCare as welfare and therefore not desirable.

6. **TV promotion at program start-up.** Our experience has shown that one of the most cost effective methods of reaching a target audience about a product is through television advertising. A well-organized TV campaign with an upbeat ad featuring Governor Tommy G. Thompson, encouraging working families to apply for BadgerCare, delivered program information to about 90 percent of our target group.

7. **Outreach efforts for all family members.** BadgerCare family coverage has simplified our outreach approach and provides a natural incentive to enroll in the new program. Materials can be designed for the entire family, and the application process can be targeted to the entire family. BadgerCare progress in enrolling children and reducing the uninsurance rate among children is double the national average for CHIP programs.

The BadgerCare policy that provides coverage for parents as part of the program has created an additional incentive to bring new families into the existing Medicaid application process. This is illustrated by the increase in the Healthy Start caseload (the application rate has doubled since July) with the implementation of BadgerCare. Households attracted by outreach efforts that appealed to all family members completed the process. Since most of these families are low income , the younger children are eligible for Healthy Start. BadgerCare brought these families in to the program.

Best Practices - Future Program Simplification

In order to minimize enrollment barriers and increase customer satisfaction Wisconsin is in the process of implementing several Medicaid and BadgerCare program simplification changes. These are listed:

1. **Wisconsin's Integrated Application Process.** We are working closely with the Department of Workforce Development to simplify our joint application and review forms and procedures. Wisconsin has been a national leader in offering an integrated application process for public assistance programs, supported by a computer system (CARES) that handles the application and redetermination requirements for Medicaid, along with food stamps, W-2, and child care benefits. With the start of the W-2 program in September 1997 we modified the CARES system so that anytime an application is processed for any of these programs, the household is automatically tested for Medicaid, unless they specifically decline to apply for Medicaid.

2. **Application forms.** Most applications are handled using an interactive interview with an eligibility worker that is supported by the CARES system, and do not use a paper application form. We do have paper application forms to use for outstation sites, and as a back up to the interactive interview. We are now making more use of the paper application form to support outstationing models and have developed a new one-page Medicaid/BadgerCare application form that will be introduced by the end of this year, to make it easier to apply.

3. **Mail and phone options for applications and redeterminations.** We are actively working on plans to plans to expand the use of phone and mail options for handling applications and reviews as part of the DHFS – DWD program planning. Exploring how to reengineer the verification functions that are handled in the eligibility determination process is another important component of this effort, and we expect to implement a number of changes to streamline the process by early next year.

4. **Notices.** A separate task force is working on improvements to the CARES generated notices, to make them easier to understand. This is important to our outreach efforts, so that families are in the best position possible to

make well-informed decisions about their program choices. The systems changes to support notice improvements are one of the Department's highest priorities for the CARES system.

5.1.2 Outreach

Best Practices

In order to effectively lay the foundation for successful implementation of BadgerCare, Wisconsin established a collaborative statewide network of health care providers (including hospitals, FQHCs, tribal health centers, and HMOs), public health agencies, local economic support social service agencies, and community based organizations.

These agencies received training to gain a better understanding of Medicaid administration. Local economic support social service agencies received a variety of special topic training that addressed many of the more complicated parts of program administration. Other groups received a more general training that dealt with eligibility and access. In addition to training, various agencies implemented outreach projects to inform customers about Medicaid.

The DHFS also published and distributed brochures and posters to local agencies (as well as doing a TV spot) to emphasize the importance of Medicaid as a health insurance program for low income working people. The training and other activities built an infrastructure and stabilized the Medicaid caseload leading toward BadgerCare implementation.

Lessons Learned

With the implementation of BadgerCare several best practices, learned with Medicaid outreach, were used. These are:

- A comprehensive media campaign (including TV spots) is important to effectively start program.
- Statewide distribution of program printed material is needed for community organizations to provide to their customers.
- Putting program information on the internet is an efficient way to disseminate information to prospective customers.
- Statewide agency infrastructure building is important to have in place before program implementation
- Program training of eligibility staff and community organizations is essential to infrastructure building and effective implementation.

- Effective data gathering methods are needed for how customer learn about the program.

The program strategy of opening up eligibility to the entire family (not just children) compliments the outreach efforts and has resulted in caseload increases in BadgerCare as well as Medicaid, in particular significant increases in the Healthy Start population. In addition, the use of a program name other than Medicaid has had a positive affect on customer program perception and has increased the percentage of new program applicants.

Evaluation of all the state's outreach efforts is currently underway, and will be completed in the near future.

5.1.3 Benefit Structure

Lessons Learned

- Building the BadgerCare administrative system on the already existing Medicaid system saved time and dollars. Using the Medicaid benefit package reduced the administrative complexity of implementing and maintaining BadgerCare. Currently 55 percent of BadgerCare families also have some members on Medicaid. Using a non-Medicaid benefit package for BadgerCare would have confused families about their coverage. Medicaid providers could have become confused about different coverage, especially Medicaid HMOs serving such mixed families. A non-Medicaid benefit package would have required extensive MMIS system changes and extensive changes in provider notification materials.

Best Practices

- BadgerCare benefits are identical to the comprehensive package of benefits and services covered by Wisconsin Medicaid. The existing Wisconsin Medicaid HMO managed care system, including provisions for quality assurance, for improved health outcomes and for grievances, is being utilized for BadgerCare.

- Wisconsin has extended health care coverage to custodial parents (and their spouses) through the 1115(a) waiver and the Title XXI state plan amendment. This family-based approach strengthens the ability of Wisconsin to achieve the Title XXI goal of providing health care to uninsured children. There is empirical evidence that a family-based approach to providing health care is more effective in enrolling children than a children-only approach to providing health care. Dr. Kenneth Thorpe of Tulane University has studied past Medicaid expansions in a large number of states. He has estimated that, on average, children-only expansions of Medicaid bring about 45 percent of potential eligibles into

the programs, whereas offering family-based expansions bring in 75 percent of potential eligibles.

Wisconsin's approach of providing family (custodial parents and spouses and children) coverage in BadgerCare has been extremely successful in meeting the key S-CHIP objective of enrolling eligible children. According to the most recent data on S-CHIP programs as indicated in HCFA's *The State Children's Health Program, Annual Enrollment Report, October 1, 1998 - September 30, 1999*, 1,979,450 children are enrolled nationally in state S-CHIP programs. This represents 24.6 percent of the 8,060,000 low-income uninsured children under 200 percent of the FPL.

In the first eight months of our program, from July 1999 through February 2000, we have enrolled 19,294 children in BadgerCare. In addition, 8,253 children have enrolled in Medicaid as a result of the BadgerCare outreach and coordination with the Medicaid program. This represents a total of 27,547 children that have enrolled in BadgerCare/ Medicaid since the implementation of the BadgerCare program in July 1999.

The most recent figures from the 1997-1998 Wisconsin Family Health Survey show that there are 54,000 low-income uninsured children under 200 percent of the FPL. BadgerCare has reduced the number of uninsured children under 200 percent of the FPL from 54,000 to 26,453. Wisconsin has enrolled 51 percent of our low-income uninsured child population in health care through the BadgerCare program compared to the national S-CHIP enrollment rate of 24.6 percent.

By June 2001, BadgerCare enrollment is projected to be 81,990, compared to 67,535 now budgeted. Higher BadgerCare enrollment will increase the number of children from nearly 19,300 currently to 25,800 by June 2001. We also project Healthy Start children will double, increasing from almost 8,300 now to almost 16,000 by June 2001. Therefore, by June 2001 we will have enrolled more than 42,000 children in BadgerCare/Medicaid, or over 77 percent of the 54,000 uninsured children under 200 percent of the FPL in Wisconsin.

- Just as welfare reform is now experimenting with creative links between cash assistance and employment, BadgerCare is an innovative and progressive model to effectively integrate Medicaid with employment-based health insurance. BadgerCare provides access to affordable health care for all uninsured children and adults in low-income families, without supplanting or crowding out employer-provided insurance. As a bold and innovative model in response to a unique and emerging social problem, BadgerCare is an opportunity to coordinate public funding of health care through Titles XIX and XXI to meet the needs of low-income, uninsured

families and children, while building a bridge between private health insurance and public health care programs.

- Building on the success of the state's existing HMO program, BadgerCare provides Wisconsin Medicaid's comprehensive benefits and services through a health care delivery system with strong quality assurance safeguards. Currently 18 of 24 licensed HMOs in Wisconsin participate in the Wisconsin Medicaid HMO program. With clear and measurable performance standards, and ongoing, continuous quality improvement activities, the Wisconsin Medicaid HMO program has demonstrated improved health outcomes. The Wisconsin Medicaid HMO contract for low-income families with children is frequently identified as one of the best in the nation.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

Best Practices

- BadgerCare eligible families with total family income equal to or greater than 150 percent of the FPL pay a premium. The premium is calculated based upon their total family income and is 3 percent of total family income.

- For applicant groups, eligibility for BadgerCare is determined for the application month and the next month. If a premium is required, the applicant must pay the premium for month two only. Month one coverage is 'free,' but requires payment of month two in order to qualify. All other payments are sent directly to a centralized premium collection site.

- Co-payments are not required of HMO BadgerCare enrollees. There is a short period of time that BadgerCare enrollees may be served through FFS. During that time enrollees pay the same co-pays as regular Medicaid recipients.

5.1.5 Delivery System

The primary delivery system for BadgerCare is Wisconsin Medicaid managed care. This was part of the design for BadgerCare.

Lessons Learned/Best Practices

- Impact of CHIP Implementation Dates and HMO Contract Dates: BadgerCare was implemented July 1, 1999. New contracts for Medicaid HMOs were not scheduled until January 2000; HMOs already had a contract to cover Medicaid recipients through December 1999. Therefore, a contract amendment to Medicaid HMOs was issued to have HMOs agree to cover BadgerCare recipients during the period July 1999 through December 1999. Because HMOs already had a contract to cover Medicaid recipients through December 1999, it was voluntary on the part HMOs whether they wished to cover BadgerCare recipients in addition.

  As a result, 10 of the current 18 Medicaid HMOs chose to participate in BadgerCare during the period July 1999 through December 1999. This result reduced the choice in the managed care program for BadgerCare recipients.

  In addition, because HMOs were not required to cover BadgerCare recipients for the July 1999 to December 1999 period, extensive changes had to be make to the MMIS HMO Enrollment system in order to accommodate this situation.

  The 2000 - 2001 contracts will require Medicaid HMOs to cover both Medicaid and BadgerCare recipients if they choose to contract with the state.

  Lesson Learned - If at all possible, implement CHIP programs/CHIP expansions on the same schedule as new Medicaid HMO contract implementations.

  Best Practices: Wisconsin Medicaid managed care has maintained its high standard for providing sufficient time and information to BadgerCare enrollees to make informed choices about enrolling in HMOs. Recipients are given 6 - 10 weeks to choose an HMO before being autoassigned, and once enrolled in an HMO have 3 months to choose another HMO. Medicaid recipients in mandatory HMO areas personally choose an HMO at a rate of 60 percent, compared to 40 percent being autoassigned. BadgerCare enrollees personally choose an HMO at the same rate.

  Wisconsin Medicaid managed care also has an excellent history of providing increased access to and quality of care to Medicaid recipients - higher use of preventive services compared to FFS (HealthCheck,

Immunizations, Pap smear tests, and Mammography tests). Although it is too soon to have complete data on the experience of BadgerCare HMO enrollees, we are assuming that their HMO experience is similar to regular Medicaid recipients.

- Evaluation Efforts: HMOs will be providing verified charge data on BadgerCare enrollees in order to assist the Department in setting adequate capitation rates for BadgerCare enrollees and cost data to establish the extent of risk sharing for excess costs.

  All Medicaid HMOs will be required to provide the Department with complete HMO encounter data beginning in May 2000 in order to allow the Department to measure access to and quality of care for regular Medicaid and BadgerCare HMO enrollees.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out

1. Best practices

   - BadgerCare was integrated into the CARES eligibility determination and the MMIS computer systems that were already being used for Medicaid. This provided the following advantages for coordination with other programs:

     - Automated logic in CARES to check first for Medicaid eligibility for BadgerCare applicants.

     - Evaluation of the existence of other insurance coverage at application by the same eligibility workers that perform Medicaid eligibility determinations.

     - Integrated BadgerCare recipients into the ongoing MMIS monthly insurance verification system, where all new eligible recipients on the MMIS are matched against insurance carrier files. This provides for a check for other insurance coverage for BadgerCare recipients that either was not verified by CARES or that began after the CARES eligibility determination had been made.

- Integrated BadgerCare recipients into the ongoing CARES/MMIS interface, where other insurance updates to the MMIS are automatically sent back to CARES for updating and eligibility worker action.

- Integrated BadgerCare recipients into the ongoing MMIS computer and fiscal agent professional staff resources for purposes of developing the Health Insurance Premium Payment (HIPP) program for the ESI/Family Coverage aspects of BadgerCare.

- Outreach activities relating to coordination with other programs:

  - BadgerCare crowd-out policies are publicized using a variety of media and access points. Television and radio spots were initially used to familiarize people with the general concept of BadgerCare. An ongoing, extensive distribution of program brochures to counties, health care facilities, employment agencies, employers and eligibility determination sites provides a source of BadgerCare crowd-out policy and eligibility information. In addition, a toll-free telephone hotline has been established to respond to specific eligibility and application questions.

  - Employer training sessions on BadgerCare policy and eligibility have been conducted in conjunction with private employer associations for the purpose of explaining crowd-out policy and the HIPP program.

  - BadgerCare crowd-out policy and eligibility information is continuously available on the BadgerCare website, including, employer fact sheets and eligibility criteria for families with access to employer-sponsored coverage.

  - A simplified application process and private insurance verification process was created.

- Multiple payment mechanisms for HIPP premiums by BadgerCare eligible families, including automated wage withholding facilitate enrollment of working families with employer-sponsored coverage.

2. Lessons learned

- Statewide, comprehensive data on employer-sponsored coverage is incomplete or sometime inaccessible. However, due to the BadgerCare HIPP program and the BadgerCare crowd-out policy of no eligibility if a family has access to ESI subsidized at 80 percent or more by the employer, the fiscal agent is developing a data base of comprehensive data on employer-sponsored coverage as part of their verification responsibilities in BadgerCare.

- Current state population estimates may not be specific to the BadgerCare applicant eligibility guidelines, i.e., families with income to 185 percent of the FPL. However, the Wisconsin Family Health Survey does categorize families from 0 percent FPL – 100 percent FPL, and 100 percent FPL – 200 percent FPL, and this does correspond to the BadgerCare recipient income limit.

5.1.7 Evaluation and Monitoring (including data reporting)

The Wisconsin Division of Health Care Financing (DHCF) has a number of BadgerCare evaluation and monitoring initiatives underway.

Best Practice: Evaluation and Monitoring of BadgerCare Recipient Access to and Quality of Care in the Medicaid Managed Care Program

Overview of Evaluation/Monitoring for Access/Quality

Medicaid HMOs were required to submit limited encounter data from all of their BadgerCare enrollees from July 1999 through December 1999. However, data from this period of time will not be complete and processed until August 2000. This data will provide preliminary indicators of BadgerCare recipient access and utilization patterns, especially in comparison with AFDC-related and poverty level pregnant women and children enrollees.

For Calendar Year 2000 Medicaid HMOs are required to complete a separate Utilization/Survey Report for BadgerCare enrollees. This is the same report Medicaid HMOs are required to complete for their AFDC-related and poverty level pregnant women and children enrollees. This report contains data on utilization of key services that represent proxies for good access to care and good quality of care. Examples of utilization indicators in the report include the following:

- Rates of HealthCheck (EPSDT) visits

- Rates of non-HealthCheck visits
- Rates of Lead Screening

- Rates of Immunization
- Rates of Pap Testing
- Rates of Mammography
- Rates of Primary Care Visits
- Rates of Mental Health/Substance Abuse Outpatient Services

Also for Calendar Year 2000 Medicaid HMOs are required to complete a number of Targeted Performance Improvement Measures (TPIM) for their combined Medicaid/BadgerCare enrollees. These are measures that require HMOs to report on specific services to those recipients who were enrolled for a minimum amount of time and thus are more accurate measures of access to and quality of care. TPIMs include measures of immunization, lead screening, and outpatient follow-up after inpatient visits for mental health and substance abuse services.

Effective January 1, 2000 all Medicaid HMOs will be required to submit complete encounter data, monthly, on all Medicaid/BadgerCare enrollees. Encounter data are a complete set of medical services provided to enrollees as stored in HMOs' administrative databases.

Finally, in Calendar Year 2000 the Wisconsin DHCF will include BadgerCare enrollees in the annual Consumer Assessment of Health Plans Survey (CAHPS) of Medicaid HMOs, in order to measure BadgerCare enrollee satisfaction with their HMOs.

Specific Best Practices:

- One key lesson and best practice is to integrate CHIP reporting into ongoing and successful State reporting on HMO. Don't try to reinvent the wheel; make use of the previous expertise, analyses, and coordinated efforts that have gone into the development of State Medicaid HMO reporting. In Wisconsin, the Medicaid HMO Utilization/Survey Report has been required for over 5 years, and has been refined to focus on key indicators, to improve the definition of indicators, and to better reflect the capability of HMO administrative data bases. State staff and medical consultants, and HMO staff, have worked cooperatively for many years to make this report an accurate measure of HMO performance in the areas of access and quality of care.

  Integrating CHIP reporting into ongoing State reporting also saves administrative costs.

- Another lesson and best practice is to use a low-level detailed reporting that can be aggregated to higher levels of generality depending on the

evaluation/monitoring focus. The Wisconsin DHCF plans to use the BadgerCare HMO enrollee encounter data to create measures of access to/quality of care that are specific to the BadgerCare population. Encounter data reporting provides allows for this flexibility.

Best Practice: Evaluation and Monitoring of BadgerCare Enrollment and Expenditures

Overview of Evaluation and Monitoring of Enrollment/Expenditures

S-CHIP legislation established the non-entitlement nature of these new child health programs.

BadgerCare is a Medicaid expansion via a Section 1115 Demonstration Waiver with an enrollment limit. Wisconsin and HCFA agreed in the waiver on an enrollment threshold procedure that would allow the State the flexibility to control BadgerCare enrollment to remain within the state budget for the program. This procedure allows that State to propose a lower income limit for new BadgerCare applicants in order to lower caseload growth in order to remain within budget. HCFA agreed to review the proposed lower income limit within 60 - 90 days.

The Wisconsin DHFS has implemented ongoing BadgerCare caseload and expenditure monitoring in order to evaluate whether the program is remaining within the state budget. The MMIS provides daily updates of caseload. State staff are able to gather data rapidly and efficiently on a weekly basis from our MMIS Data Warehouse through Business Objects™ - an integrated query, reporting, and data analysis software package. We use this data to project caseload and expenditures from 2 - 18 months in the future.

We are also able to access data from the CARES database, the state's eligibility determination computer system to determine remaining CARES caseload with at least one member that is eligible for TANF, Food Stamps, or Medicaid that that scheduled for a periodic review and that have case members that are potentially eligible for BadgerCare.

Finally, we monitor BadgerCare caseload within CARES by income levels (per increments of 10 percent of FPL) in order to determine where to lower the applicant income limit if it becomes necessary to do so in order to stay within the state budget.

Specific Best Practice

- **Best Practice - Timely, Accurate and Rapidly Accessible Information:** Up to date and easily obtained caseload and expenditure information is essential for States to evaluate the impact of their CHIP programs on their state budgets. Wisconsin has been able to monitor BadgerCare caseload

and expenditures on a weekly basis and to make accurate projections based on this data due to our Data Warehouse of Medicaid data. The Data Warehouse is specifically designed for the production of rapid and reliable queries, reports, and analysis by Division of Health Care Financing staff through the use of Business Objects™ software.

Best Practice: Evaluation and Monitoring of Outreach, Crowd-out, and Other BadgerCare Program Aspects

Overview of Evaluation and Monitoring of Outreach, Crowd-out, Other

Wisconsin has a series of ongoing evaluations and monitoring, and planned evaluations, of other aspects of BadgerCare, including outreach and crowd-out.

For outreach, we collect information from our two toll-free BadgerCare inquiry phone lines on how persons have learned about BadgerCare. We conduct regular surveys of applicants and staff at our outstation sites on the usefulness and effectiveness of outstations. We perform ongoing evaluation/surveys of attendees at our BadgerCare/Medicaid training sessions on which aspects of the training were effective.

An evaluation report on Medicaid/BadgerCare outreach is being prepared for the Wisconsin State Legislature.

Best practices/lessons learned about outreach can be found in Section 5.1.2.

For crowd-out, we collect ongoing information from the CARES eligibility determination computer system on BadgerCare applicants/recipients that are denied/terminated due to coverage by other insurance or access to employer-sponsored insurance subsidized at 80 percent or more.

In addition, we collect program statistics on our ESI/Family Coverage program that measure program efficiency: numbers of families with access to ESI; number of families that have undergone the cost effectiveness/family coverage test; numbers of families found to be cost-effective for ESI buy-in; numbers of families bought-in to ESI/Family Coverage; etc.

Finally, as part of our Section 1115 waiver, we have a long-term evaluation component that will measure the impact of the BadgerCare program on the private insurance industry through employer/carrier surveys and other methods.

Specific Best Practices

- See Sections 5.1.2 and 5.1.6 for lessons learned/best practices on operations in the areas of outreach and crowd-out.

- In general, ongoing monitoring is essential for the refinement of BadgerCare/Medicaid outreach methods. The evaluation of BadgerCare crowd-out methods and their impact on the potential applicants and on employers is a more complex task that requires long-term methods of evaluation.

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

Plans for Improving Availability of Health Insurance and Health Care for Children Within BadgerCare

- The current budget authorizes funding for 67,535 uninsured children and adults with income not exceeding 185 percent of the FPL. However, given the success of the BadgerCare program enrollment may exceed budgeted amounts. To cover the projected enrollment, Governor Thompson has proposed additional funding for BadgerCare. Currently, $56.6 million in state (GPR) funding and $101.8 million in federal (FED) funding is budgeted for BadgerCare in the 1999-01 biennium. Legislation has been introduced to further increase BadgerCare funding by $20.7 million GPR and $23.6 million FED.

- Wisconsin plans to ease the BadgerCare application and eligibility determination process by implementing a 1-2 page application for Medicaid/BadgerCare that can be mailed in or taken over the telephone, reducing the need for a face-to-face interview at local county department of social services office. We also plan to ease the BadgerCare application and eligibility determination burden on families by streamlining the documentation and verification process.

- Wisconsin plans to improve the continuity of BadgerCare coverage for adults and children by streamlining the premium notification/collection process for families required to pay a 3 percent monthly premium (those families with net family income over 150 percent of the FPL).

Plans for Improving Availability of Health Insurance and Health Care for Children Outside of BadgerCare

- A provision of 1999 Wisconsin Act 9 (the 1999 - 2001 biennial budget act) authorizes the design and operation of a private employer health care coverage program. The legislation, in part, provides infrastructure to create a new risk pool for small business employers to purchase group health insurance for their employees. Small businesses are more likely to be affected by small group rating practices, including premium increases, and often lack the stability and capacity to administer employee benefits programs. We expect that during this biennial budget period of July 1999 through June 2001, this new risk pool will become operational and increase the availability of health insurance and health coverage for children and adults.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

HCFA Should Allow Section 1115 Waivers of Title XXI Requirements

HCFA should allow waivers of Title XXI requirements as provided for in Section 2107(e)(2)(A) of the Title XXI provisions of the BBA. This would allow states to design CHIP programs with maximum flexibility and more attuned to local conditions. For example, Wisconsin desired to cover adults in BadgerCare as a matter of good public policy and for practical purposes: more eligible children are enrolled when a public health program is offered to the entire family, rather than children alone. Yet we were only able to cover adults through the design of BadgerCare as a Medicaid expansion and the use of a Medicaid Section 1115 waiver. This process took over a year of negotiations with HCFA.

Wisconsin submitted a waiver amendment on March 10, 2000, to request Title XXI funds for BadgerCare adults.

DHHS and USDA Should Assure Uniform Administration of Medicaid, CHIP, and Food Stamp Programs

DHHS should update "FAMIS" standards and provide 90 percent federal match rates for the administrative costs in reengineering eligibility systems. The old model for integrated eligibility determination systems - Family Assistance Management Information Systems or "FAMIS" - has been rendered obsolete by the repeal of the AFDC program and creation of the Temporary Assistance to Needy Families (TANF) block grants to the state.

In order to upgrade and reengineer their automated systems to support the current program mix and realize the benefits of integrated systems, States need enhanced federal funding at the 90 percent federal matching rate, and technical assistance from the DHHS.

HCFA Should Remove Restrictions They Have Placed on CHIP ESI Programs

HCFA should remove restrictions they have imposed on state buy-in of employer-sponsored insurance (ESI) in CHIP programs. Specifically, HCFA should remove the restriction that the employer share of the cost of family coverage should be between 60 percent to 80 percent. The major criterion for state buy-in of ESI should be that it be cost-effective compared to the regular CHIP benchmark benefit package. In addition, HCFA should remove the restriction that the family has not been enrolled in the ESI for a period between 6 - 12 months.

The cost effectiveness of an insurance premium buy-in is not necessarily dependent upon the percentage of the employer contribution. Instead of using any baseline percentage of employer contribution as a means of determining an employee's eligibility for family premium assistance, each determination should be based upon the overall cost effectiveness of the buy-in. In addition, stipulating any federal or state percentage requirement for CHIP participation gives employers a target that can be misused. By arbitrarily reducing its percentage of contribution, the employer can eliminate the opportunity for additional CHIP-sponsored employees to purchase employer health care benefits.

Documentation from the first 5 months of Wisconsin's Badger Care Program shows a total of 356 eligible individuals who have been identified as having access to employer-sponsored group health coverage that meets HIPAA requirements. Only 9 or 2.5 percent of these eligible individuals have access to family coverage where the employer pays 60 percent or more of the premiums. On the other hand, nearly 30 percent of the 356 eligible individuals have access to employer-sponsored insurance where the employer contributes in a range of 10 percent less than the 60 percent minimum. Unfortunately, under the current proposed rules, the overall cost effectiveness of buying in these eligible individuals cannot be considered as an option.

As for the 6 - 12 "look back" period, states should be allowed to design the length of these periods that are in accordance with the general crowd-out provisions they have instituted in their CHIP programs.

APPENDIX 1

OVERVIEW OF THE CURRENT AND PLANNED WISCONSIN MEDICAID HMO QUALITY IMPROVEMENT ACTIVITIES

- Overview of the Key Elements of the Wisconsin Medicaid HMO Quality Assurance Performance Improvement (QAPI) Plan

- Calendar Year 1997 Wisconsin Medicaid HMO Comparison Report. Section 3 of this report provides an overview of our current quality improvement activities, which are applicable to calendar years 1998, 1999, 2000, and 2001.

- A Brochure describing 4 workshops to be held around the state in the Spring/Summer of 2000 for HMOs and other interested parties described DHFS strategies/methodology for measurement of Wisconsin HMO quality of clinical care.

- A Brochure described a DHFS sponsored statewide conference on Improving HealthCheck performance in the Spring of 2000.

Key Elements